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ABSTRACT

The revised manual of nursing procedures covers fundamental nursing care, admission and discharge of the patient, assisting with therapeutic measures, pre- and postoperative care, diagnostic tests and procedures, and isolation technique. Each of the over 300 topics includes the purpose, equipment, and procedure to be used and, where relevant, such items as points to emphasize, care of equipment, and diagrams. The document is indexed. (MS)

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NURSING
PROCEDURES

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Nursing Division
Bureau of Medicine and Surgery
Department of the Navy
Washington, D. C. 20390

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FORWARD

This manual is intended to be utilized as a guide for nonprofessional personnel. So many changes have taken place since this manual was last published in 1967 that a complete revision was necessary. This was accomplished through the efforts of a committee which spent many weeks bringing it up-to-date. The professional judgment of medical officers and Nurse Corps officers at local commands will determine any changes in the outlined procedures.

D. L. CUSTIS
Vice Admiral, MC, USN
Chief, Bureau of Medicine and Surgery

PREFACE

This is the second revision of NURSING PROCEDURES which was first published in 1960. Because of the many advances in medicine and changes in nursing techniques, it became necessary to update this manual. A committee composed of the following members

CAPT Dolores Cornelius NC USN
CAPT Norma H. Gardill NC USN
LCDR Mary L. Young NC USN
LCDR Jean Rollins NC USN
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LTJG David H. Minzes NC USNR

met at the Naval Medical Training Institute, Bethesda, Maryland to review the nursing procedures and determine what changes, additions, or deletions should be made. They found that many of the procedures were still basically sound, but the equipment used to carry them out had changed. For this reason, it was necessary to update the majority of procedures included in the manual.

We are indebted to the Nurse Corps officers at the Hospital Corps Schools San Diego and Great Lakes for their extensive reviews and suggestions for revision of this manual. Additionally, the fine revised illustrations are the work of Michael Willhoite, HM3, of the Naval Medical Training Institute.

Special recognition is given to Vivian Ann Brown of the Nursing Division who typed the entire revision of the manual.

Alene B. Duerk
ALENE B. DUERK
Rear Admiral, NC, USN
Director, Navy Nurse Corps

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I

FUNDAMENTAL NURSING CARE OF THE PATIENT

MORNING CARE

PURPOSE

To refresh and prepare patient for breakfast.

EQUIPMENT

Basin of warm water
Towel, washcloth and soap
Toothbrush and dentifrice/mouthwash
Curved basin
Glass of water
Comb

PROCEDURE

1. Clear bedside stand or overbed table for food tray.
2. Offer bedpan and urinal.
3. Wash patient's face and hands.
4. Give oral hygiene.
5. Place patient in a comfortable position for breakfast.
6. Comb hair.

POINTS TO EMPHASIZE

1. Morning care is given before breakfast by night corpsman.
2. Assist handicapped, aged or patients on complete bed rest.

CARE OF EQUIPMENT

Wash, dry and replace equipment.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ORAL HYGIENE

PURPOSE

To keep mouth clean.
To refresh patient.
To prevent infection and complications in the oral cavity.
To stimulate appetite.

EQUIPMENT

Glass of water
Curved basin
Toothbrush and dentifrice - electric toothbrush if available
Mouth wash
Towel
Drinking tubes as necessary

PROCEDURE

1. A patient who is able to help himself:
    a. Place patient in comfortable position.
    b. Arrange equipment on bedside table within his reach.

2. A patient who needs assistance:
    a. Place patient in comfortable position.
    b. Place towel under his chin and over bedding.
    c. Moisten brush, apply dentifrice and hand to the patient.
    d. Hold curved basin under his chin while he cleanses his teeth and mouth.
    e. Remove basin. Wipe lips and chin with towel.

POINTS TO EMPHASIZE

Oral hygiene is particularly important for patients
  a. who are not taking food and fluid by mouth
  b. with nasogastric tubes
  c. with productive coughs
  d. who are receiving oxygen therapy

CARE OF EQUIPMENT

Wash equipment with soap and hot water, rinse, dry and put away.

ORAL HYGIENE (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SPECIAL MOUTH CARE

PURPOSE

To cleanse and refresh mouth.
To prevent infection.

EQUIPMENT

Electric toothbrush if available
- Tray with:
  - Mineral oil or cold cream
  - Lemon-glycerine applicators
  - Paper bag
  - Drinking tubes or straws
  - Applicators and gauze sponges
  - Curved basin
  - Paper wipes
  - Bulb syringe

Cleansing agents

- Tooth paste
- Equal parts of hydrogen peroxide and water
- Mouthwash

Glass of water
Suction machine for unconscious patient

PROCEDURE

1. Tell patient what you are going to do.
2. Turn patient's head to one side.
3. Brush teeth and gums.
4. When it is not possible to brush teeth and gums, moisten applicator with a cleansing agent and use for cleaning oral cavity and teeth.
5. Assist patient to rinse mouth with water.
6. If patient is unable to use drinking tube, gently irrigate the mouth with a syringe directing the flow of water to side of mouth.
7. Apply lubricant to lips.

For Unconscious Patient

Use suction machine.

SPECIAL MOUTH CARE (Continued)

POINTS TO EMPHASIZE

1. Extreme care should be exercised to prevent injury to the gums.
2. Position patient carefully to prevent aspiration of fluids.
3. Caution patient not to swallow mouthwash.

CARE OF EQUIPMENT

Dispose of applicator and soiled gauze. Clean equipment and restock tray.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CARE OF DENTURES

PURPOSE

To aid in keeping mouth in good condition.
To cleanse the teeth.

EQUIPMENT

Container for dentures
Toothbrush and dentifrice
Glass of water
Mouthwash
Curved basin
Towel
Paper towels

PROCEDURE

1. Have patient rinse mouth with mouthwash.
2. Remove dentures. Place them in container.
3. Have patient brush tongue and gums with mouthwash.
4. Place a basin under tap in sink and place paper towels in basin. Fill basin with cold water.
5. Hold dentures over basin and under cold running water. Wash with brush and dentifrice.
6. Place dentures in container of cold water. Take to patient's bedside.
7. Replace wet dentures.

POINTS TO EMPHASIZE

1. Handle dentures carefully to prevent breakage.
2. When not in use, dentures should be placed in covered container of cold water and placed in top drawer of locker.
3. Give special attention to the inner surfaces of clips used to hold bridge work or partial plates in place.

CARE OF EQUIPMENT

Wash equipment, rinse, dry and put away.

CARE OF DENTURES (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

BED BATH

PURPOSE

To cleanse the skin.
To stimulate the circulation.
To observe the patient mentally and physically.
To aid in elimination.

EQUIPMENT

Linen and pajamas as required
Half filled basin of water
Bar of soap
Rubbing alcohol/skin lotion
Bedpan and urinal with cover
Bed screens

PROCEDURE

1. Tell patient what you are going to do.
2. Screen patient.
3. Offer bedpan and urinal.
4. Shave patient or allow patient to shave himself.
5. Lower backrest and knee rest if physical condition permits.
6. Loosen top bedding at foot and sides of bed.
7. Remove pillow and place on chair.
8. Remove and fold bedspread and blanket. Place on back of chair.
9. Remove pajamas and place on chair.
10. Assist patient to near side of bed.
11. Bathe the patient:

    a. Eyes:

        (1) Do not use soap.
        (2) Clean from inner to outer corner of eye.
    b. Face, neck and ears.
    c. Far arm.
    d. Place hand in basin and clean nails.
    e. Near arm.
    f. Place hand in basin and clean nails.
    g. Chest.
    h. Abdomen.

BED BATH (Continued)

PROCEDURE (Continued)

12.
    - i. Far leg, foot and nails. Place foot in basin when possible.
    - j. Near leg, foot and nails. Place foot in basin when possible.
    - k. Change water.
    - l. Back and buttocks.
    - m. Genitals and rectal area.
13. Give back rub.
14. Put on pajamas.
15. Comb hair.
16. Make bed.
17. Adjust bed to patient's comfort unless contraindicated.

POINTS TO EMPHASIZE

1. Give bed baths daily and P.R.N.
2. Give oral hygiene before bath.
3. Avoid drafts which might cause chilling.
4. Use bath towel under all parts to aid in keeping the bed linen as dry as possible.
5. Change bath water after washing lower extremities and as necessary.
6. Be sure all soap film is rinsed from body to prevent skin irritation.
7. Keep patient well draped at all times.
8. Observe and chart the condition of the skin in regard to lesions, rashes and reddened areas.
9. Pillow should be removed unless contraindicated to give patient a change of position.
10. Assist handicapped patients with shaving.
11. Always move or turn patient toward you.

CARE OF EQUIPMENT

1. Remove soiled linen and place in hamper.
2. Wash equipment, rinse, dry and put away.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

BED BATH (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

MAKING AN UNOCCUPIED BED

PURPOSE

To provide a clean, comfortable bed.
To provide a neat appearance to the ward.

EQUIPMENT

Two sheets
Plastic mattress cover
Blanket
Plastic pillow cover
Pillowcase
Protective draw sheet or disposable pads, if indicated

PROCEDURE

1. Place mattress cover on mattress. Where necessary and available, plastic mattress covers are used.
2. Place center fold of sheet in center of bed, narrow hem even with foot of bed.
3. Fold excess sheet under the mattress at head of bed.
4. Miter corner.
    a. Pick up hanging sheet 12 inches from head of bed.
    b. Tuck lower corner under mattress.
    c. Bring triangle down over side of bed.
    d. Tuck sheet under mattress.
5. Pull bottom sheet tight and tuck under side of mattress.
6. If draw sheets are indicated, place in center of bed as illustrated. Tuck excess under mattress.
    a. Linen draw sheet is made by folding a regular bed sheet in half - hem to hem.
7. Place center fold of second sheet in center of bed, with hem even with the top of mattress.
8. Tuck excess under foot of mattress.
9. Center fold blanket in middle of bed 6 inches from top of mattress.
10. Fold excess under foot of mattress.
11. Make mitered corner.

MAKING AN UNOCCUPIED BED (Continued)

PROCEDURE (Continued)

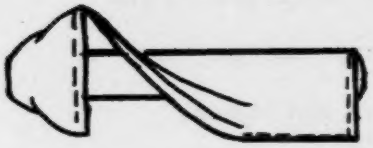
12. Place bedspread on bed, center fold in middle of bed even with the top of the mattress. Fold under blanket.
13. Fold cuff of top sheet over bedspread at head of bed.
14. Tuck excess spread under foot of mattress.
15. Miter corner at foot of mattress.
16. Go to other side of bed and follow steps 3 to 15.
17. Place plastic cover on pillow.
18. Place pillow case on pillow.
19. Place pillow on bed with seams at head of bed, open end away from the entrance to the ward.

POINTS TO EMPHASIZE

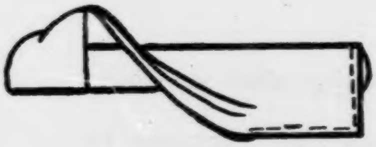
1. Woolen blankets are to be used only when cotton blankets are not available.
2. Never use woolen blankets when oxygen therapy is in use.
3. Use protective draw sheet or protective pads when indicated.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

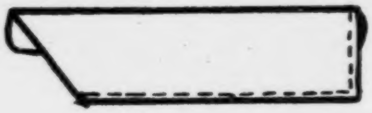
MITERED CORNER



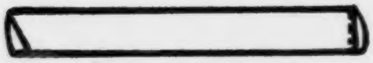
Pick up hanging sheet 12 inches from head of bed.



Tuck lower corner under mattress.



Bring triangle down over side of bed.



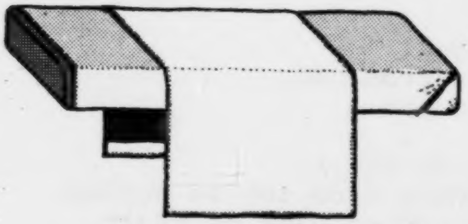
Tuck sheet under mattress.

COMPLETING FOUNDATION

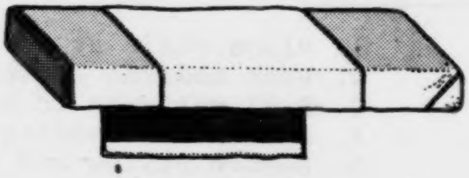
APPLY DRAW SHEETS

1. PLACE RUBBER DRAW SHEET IN CENTER OF BED

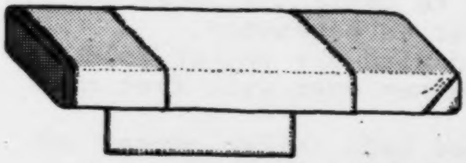
2. TUCK EXCESS RUBBER DRAW SHEET IN ON NEAR SIDE OF MATTRESS



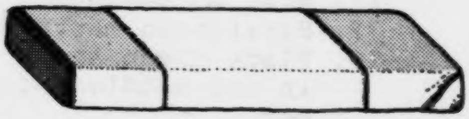
3. PLACE COTTON DRAW SHEET OVER RUBBER DRAW SHEET



4. TUCK EXCESS COTTON DRAW SHEET IN ON NEAR SIDE OF MATTRESS



5. TUCK EXCESS RUBBER DRAW SHEET IN ON OPPOSITE SIDE OF MATTRESS



6. TUCK EXCESS COTTON DRAW SHEET IN ON OPPOSITE SIDE OF MATTRESS

MAKING AN OCCUPIED BED

PURPOSE

To provide clean linen with least exertion to patient.
To refresh patient.
To prevent pressure sores.

EQUIPMENT

Two sheets
Pillowcase
Blanket
Protective draw sheet or disposable pads, if indicated
Hamper

PROCEDURE

1. Place chair at foot of bed.
2. Push bedside locker away from bed.
3. Pull mattress to head of bed.
4. Loosen all bedding.
5. Remove pillow and place on chair.
6. Remove bedspread by folding from top to bottom, pick up in center and place on back of chair.
7. Remove blanket in same manner.
8. Turn patient to one side of the bed.
9. If cotton draw sheet is used, roll draw sheet close to patient's back.
10. Turn back protective sheet over patient.
11. Roll bottom sheet close to patient's back.
12. Straighten mattress cover as necessary.
13. Place clean sheet on bed with the center fold in the middle and narrow hem even with foot of bed.
14. Tuck in excess at head of bed. Miter corner and tuck in at side.
15. Bring down protective sheet; straighten and tuck in.
16. Make draw sheet by folding a sheet from hem to hem with smooth side out.
17. Place on bed with fold toward head of bed. Tuck in.

MAKING AN OCCUPIED BED (Continued)

PROCEDURE (Continued)

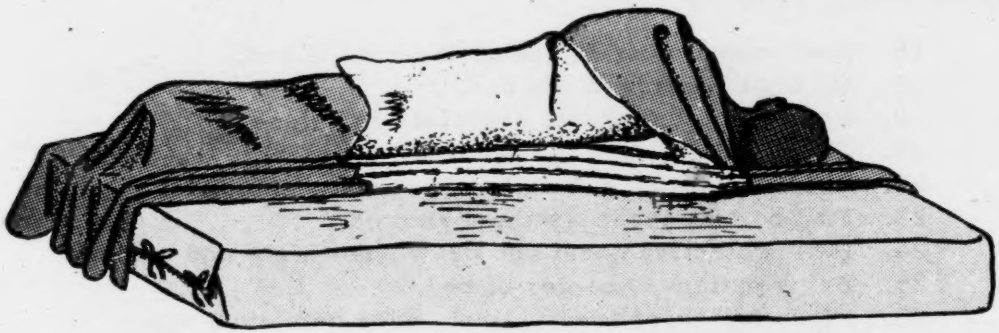
18. Roll patient over to completed side of bed.
19. Go to other side of the bed.
20. Remove soiled sheets and place in hamper.
21. Check soiled linen for personal articles.
22. Turn back draw sheets over patient.
23. Pull bottom sheet tight and smooth.
24. Pull protective sheet and draw sheet tight and smooth.
25. Bring patient to center of bed.
26. Place top sheet over patient, wide hem even with top of mattress.
27. Ask patient to hold clean top sheet.
28. Remove soiled top sheet. Place in hamper.
29. Place blanket 6 inches from top of mattress.
30. Make pleat in sheet and blanket over patient's toes.
31. Tuck in excess at foot of bed and miter corners.
32. Place bedspread on bed even with top of mattress. Fold under blanket.
33. Fold sheet over bedspread and blanket at head of bed.
34. Tuck in excess bedspread at foot of bed. Miter corners. Allow triangle to hang loosely.
35. Put clean pillowcase on pillow. Place under patient's head with closed end toward entrance to ward.
36. Adjust bed as desired by patient.
37. Straighten unit. Leave bedside stand within reach of patient.

POINTS TO EMPHASIZE

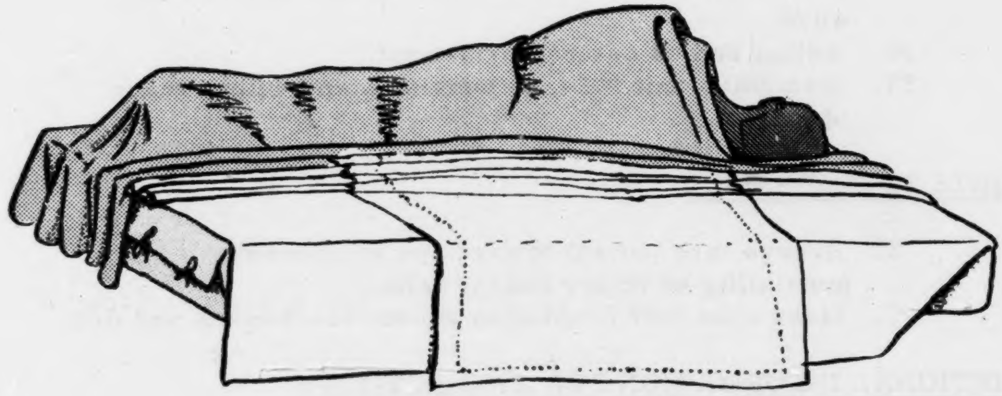
1. Always turn patient toward you to prevent possibility of injury and/or falls.
2. Make sure that foundation sheets are smooth and dry.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

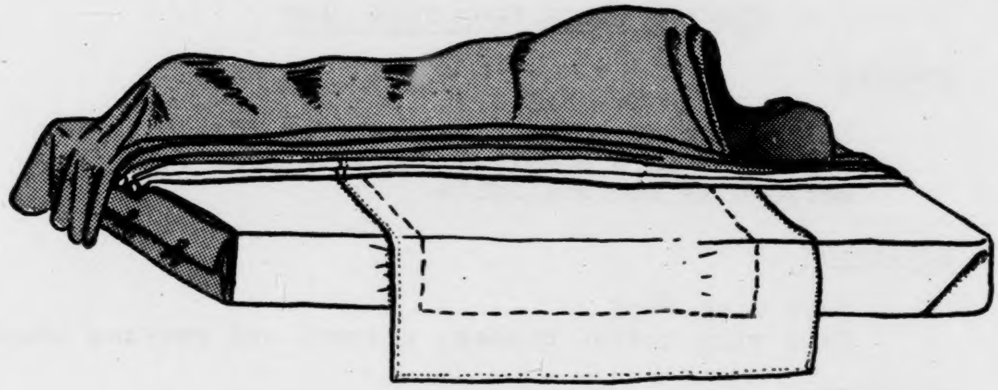
MAKING AN OCCUPIED BED



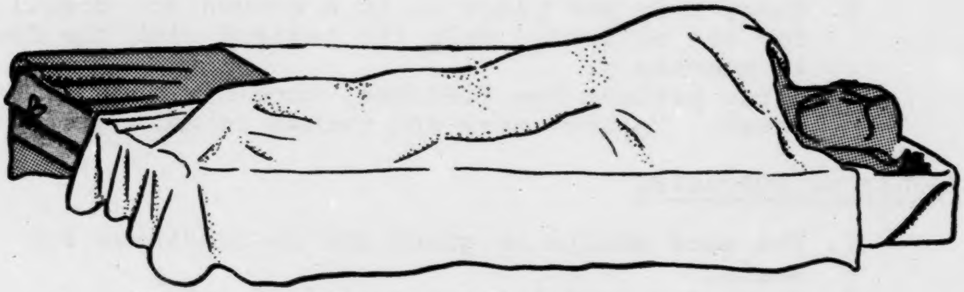
TURN PATIENT TOWARD YOU
FAN FOLD SOILED LINEN AGAINST
PATIENTS BACK



MAKE UP ONE HALF THE BED
BOTTOM SHEET, THEN
RUBBER DRAW SHEET



ADD COTTON DRAW SHEET



TURN PATIENT ONTO CLEAN LINEN
MAKE OPPOSITE SIDE OF BED

SERVING DIETS FROM FOOD CART

PURPOSE

To provide an attractively served food tray for a patient in a hospital where central food tray service is not available.

EQUIPMENT

Cart with food
Cart with trays, dishes, silver, and serving utensils

PROCEDURE

1. Clear the patient's bedside or overbed table.
2. Place table within patient's reach.
3. Place patient in a comfortable position.
4. Wash hands. Wheel food and tray carts to the unit.
5. Place beverage, salad, soup and dessert on the tray.
6. Fill glasses, cups and bowls three fourths full.
7. Serve small portions of hot food in an attractive manner.
8. Check diet list for type of diet each patient is to receive.
9. Carry tray and place it in a convenient position for the patient. Help the patient with the food if necessary.
10. After patient has finished, note how much he has eaten. Collect tray and return to main galley.

POINTS TO EMPHASIZE

1. The ward should be quiet and in readiness for meals.
2. Serve hot food hot and cold food cold.
3. Ice cream, sherbert and jello are kept in the refrigerator until ready to serve.
4. Do not hurry patient.
5. Do not smoke while working with food.
6. Refer to Special Diet Manual for special diet information.
7. Check visible file to determine if patient may have regular diet.
8. Make rounds to check that every patient has been served and received the correct diet.

SERVING DIETS FROM FOOD CART (Continued)

CARE OF EQUIPMENT WHERE MAIN GALLEY DOES NOT HAVE DISH WASHING FACILITIES

1. Scrape and stack dishes:
   a. Solid food into garbage can.
   b. Liquids into drain.
2. Clean and stack trays.
3. Wash dishes with hot soapy water. Stack in dish sterilizer.
4. Follow instructions on sterilizer. Temperature of final rinse water 180° F. Allow to air dry. Put away.
5. Place trays on cart with tray cover, silver and napkins. Salt, pepper, sugar go on all trays except Special Diets.
6. Clean food cart. Return to main galley.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CENTRAL TRAY SERVICE

PURPOSE

To provide attractively served food to the patient in an efficient manner.

PROCEDURE

1. Check list of patients who are not permitted food or fluids by mouth.
2. Clear bedside or overbed table.
3. Place table within reach of patient.
4. Place patient in comfortable position.
5. Wash hands. Wheel cart with trays to unit.
6. Take tray from cart and check to see if it is complete.
7. Read tray card.
8. See that tray is served to patient listed on the selective menus or the Special Diet Request that is placed on each tray.
9. Call each patient by name or check his identification band. Place his tray within easy reach.
10. Feed patient or assist him as necessary such as buttering his bread, cutting his meat, etc. Allow patient to do as much for himself as possible.
11. Make rounds to check that each patient entitled to a tray has been fed. The Diet List may be used as a check off list.
12. After the patient has finished eating, collect tray immediately and return to cart. Make a note of food eaten and record on Intake and Output Sheet as indicated.
13. Report all complaints about food to Food Service.

POINTS TO EMPHASIZE

1. Serve trays promptly.
2. Do not hurry patient.
3. Make rounds to check that all patients have been fed.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CARE OF ICE MACHINE AND HANDLING OF ICE, BEDSIDE PITCHERS, AND GLASSES

PURPOSE

To prevent ice machines from becoming a source of infection due to cross-contamination.

EQUIPMENT

To clean and disinfect ice machine:

- Clean gloves, disposable
- 4 x 4 sponges
- Scouring powder
- Sodium hypochlorite
- Clean 1 gallon container
- Clean ice scoop

PROCEDURE

1. Disconnect ice machine from electrical outlet.
2. Wash hands.
3. Use ice scoop to dispose of any existing ice. Pour tap water into ice storage compartment to melt any remaining ice.
4. Put on gloves and remove scale and other debris with 4 x 4 sponges and scouring powder.
5. Rinse thoroughly with tap water.
6. Place 1/2 ounce of sodium hypocholrite in 1 gallon of water.
7. Using 4 x 4's wipe all accessible areas of interior with sodium hypochlorite solution. Pay particualr attention to ice chute.
8. Repeat step #7.
9. Allow solution to remain in machine for 30 minutes.
10. Rinse thoroughly with clean tap water three times.
11. Clean the exterior of the ice machine.
12. Connect ice machine to electrical outlet.

POINTS TO EMPHASIZE

1. Keep exterior of machine clean between weekly disinfecting of interior.
2. Limit access to ice machine to nursing service personnel.
3. Always keep door closed when not removing ice.
4. Locate ice machine in a "clean" area of the ward or hospital.

CARE OF ICE MACHINE AND HANDLING OF ICE, BEDSIDE PITCHERS, AND GLASSES (Continued)

POINTS TO EMPHASIZE (Continued)

5. If ice must be transported, containers should be clean and covered.
6. Use a scoop or tongs when handling ice. Never handle ice with bare hands.
7. Never store the scoop in the ice when not in use.
8. The scoop or tongs must be sanitized at least daily.
9. Each patient should have his own bedside water pitcher with cover.
10. Glasses used for drinking water should be sent to the kitchen for exchange of clean glasses on a routine basis.
11. Culture ice machines according to local hospital policy and record in ice culture log.

CARE OF EQUIPMENT

1. Discard disposable equipment.
2. Replace cleaning gear.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

FEEDING THE HELPLESS PATIENT

PURPOSE

To promote adequate nutrition of the helpless patient.
To encourage self-help when condition permits.

PROCEDURE

1. Place the patient in a sitting position unless otherwise ordered.
2. Place a towel across the patient's chest. Tuck a napkin under his chin.
3. Place tray on overbed table or bedside stand.
4. Give the patient a piece of buttered bread if he is able to hold it.
5. Feed the patient in the order in which he likes to be fed.
6. Offer liquids during the meal. Have patient use a drinking tube if necessary.
7. Give a small amount of food at one time. Allow the patient to chew and swallow food before offering him more. Do not rush your patient.
8. If patient is inclined to talk, talk with him.
9. Note amount of food he has taken. Record amount of fluid if on measured intake and output.
10. Remove tray. Leave patient comfortable.

POINTS TO EMPHASIZE

1. As you are feeding a blind patient tell him what you are offering and whether it is hot or cold.
2. Encourage a blind patient to begin feeding himself as soon as he is able and when indicated.
3. When encouraging a blind patient to feed himself, arrange tray the same way each time. Place foods on plate in the same clockwise direction and fill glasses and cups one-half full to avoid spilling.
4. If patient has difficulty in swallowing, have oral suction machine at bedside.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

EVENING CARE

PURPOSE

To relax and prepare patient for the night.
To observe the patient's condition.

EQUIPMENT

Basin of warm water
Towel, washcloth and soap
Toothbrush, and dentifrice/mouthwash
Curved basin
Glass of water
Rubbing alcohol/skin lotion
Comb

PROCEDURE

1. Offer bedpan and urinal.
2. Give oral hygiene.
3. Wash patient's face and hands.
4. Wash back. Give back rub. Comb hair.
5. Straighten and tighten bottom sheets.
6. Freshen pillows.
7. Place extra blanket at foot of bed if weather is cool.
8. Make provision for ventilation of unit.
9. Clean and straighten unit and remove excess gear.

POINTS TO EMPHASIZE

1. Indicated for all bed patients and those on limited activity.
2. Change soiled linen as necessary.
3. Patient may assist with care as condition permits.
4. Ask the patient if soap may be used on the face.
5. Screen patients who require the use of bedpan.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TAKING ORAL TEMPERATURE
THERMOMETERS DISINFECTED ON WARD

PURPOSE

To determine the patient's body temperature as recorded on a clinical thermometer.

EQUIPMENT

1. Tray containing:
    a. Two containers of disinfecting agent marked #1 and #2
    b. Container of green soap solution
    c. Container of water
    d. Container of clean cotton
    e. Waste container for soiled cotton
    f. Minimum of 6 thermometers, 3 in each container of disinfecting solution
    g. T.P.R. book
    h. Pencil and pen
    i. Watch with second hand

PROCEDURE

1. Take equipment to bedside.
2. Tell the patient what you are going to do.
3. Remove thermometer from container #1.
4. Wipe thermometer (over waste container) with water moistened sponge from stem to bulb using rotary motion. Discard sponge in waste container.
5. Shake down thermometer mercury to 95° F.
6. Place thermometer under patient's tongue. Caution him to keep his lips closed.
7. Distribute other thermometers to second and third patients in same manner.
8. Take third patient's pulse and respiration. Record results in T.P.R. book.
9. Take pulse and respiration of second patient, record, then first patient. Record results in T.P.R. book.
10. Remove thermometer from first patient's mouth after 3 minutes.
11. Wash thermometer (over waste container) with soap-moistened sponge from stem to bulb using rotary motion. Discard sponge in waste container.

TAKING ORAL TEMPERATURE (Continued)
THERMOMETERS DISINFECTED ON WARD

PROCEDURE (Continued)

12. Moisten cotton sponge with water and wipe thermometer from stem to bulb in a rotary container. Discard sponge in waste container.
13. Read thermometer. Record results in T.P.R. book.
14. Place thermometer in the original container of disinfecting agent.
15. Repeat the steps 10 through 13 for second and third patients.
16. Disinfect these thermometers for a minimum of 20 minutes (depending on disinfecting agent used).
17. Continue using thermometers from alternate containers until all patient's temperatures have been taken.
18. Record T.P.R.'s on SF 511.

CARE OF EQUIPMENT

1. After each use
   a. Remove waste.
   b. Clean tray.
   c. Reset tray.
   d. Replace solutions (water - soap).
2. Daily
   a. Wash containers in warm, soapy water, rinse and dry.
   b. Change all solutions.
   c. Wash thermometers in cold, soapy water, rinse and place in disinfecting agent.
   d. Refill and reset tray.

POINTS TO EMPHASIZE

1. Wait for 10 minutes before taking temperature of patient who has had hot or cold drink or who has been smoking.
2. Be sure thermometer reads 95° or below before using it.
3. Encircle abnormal vital signs with red pencil in T.P.R. book.
4. Report all abnormal vital signs to Charge Nurse.
5. Describe quality of pulse and respiration in the observation column on Nursing Notes (SF 510).

TAKING ORAL TEMPERATURE (Continued)
THERMOMETERS DISINFECTED ON WARD

POINTS TO EMPHASIZE (Continued)

6. After washing thermometer with soap, be sure to rinse well with water before putting it into disinfectant, as bacterial action is nullified in the presence of soap; for example, Zephiran chloride and iodine preparations.
7. Individual thermometers should be used for patients suspected of having a communicable disease.

THERMOMETERS STERILIZED IN CENTRAL SUPPLY ROOM

EQUIPMENT

1. Tray containing:

   a. Container of sterile oral thermometers that are sealed in paper envelopes.
   b. Container of green soap solution.
   c. Container of clean cotton.
   d. Container for waste material.
   e. T.P.R. book.
   f. Pencil.
   g. Watch with second hand.

PROCEDURE

1. Tell the patient what you are going to do.
2. Remove thermometer from envelope.
3. Shake thermometer mercury to 95° F.
4. Place thermometer under patient's tongue. Caution him to keep his lips closed.
5. Take, record and report vital signs as in previous procedure, numbers 7 through 11, pages 25 and 26.

CARE OF EQUIPMENT

1. After each use:
   a. Empty container of waste cotton.
   b. Return container of soiled thermometers to CSR in accordance with local instructions and exchange for an adequate supply of clean thermometers.
   c. Reset tray.
2. Daily:
   a. Wash containers in warm, soapy water, rinse and dry.
   b. Refill and reset tray.

TAKING ORAL TEMPERATURE (Continued)
THERMOMETERS STERILIZED IN CENTRAL SUPPLY ROOM

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TAKING ORAL TEMPERATURE
INDIVIDUAL THERMOMETER TECHNIQUE

PURPOSE

To determine the patient's body temperature as recorded on a clinical thermometer.

EQUIPMENT

1. Individual thermometer for each patient at bedside
2. Plastic thermometer holder with disinfectant solution - protective container of 2 1/2 cc. disposable syringe can be used
3. Adhesive tape
4. Container of clean cotton balls
5. Container for soiled cotton balls
6. T.P.R. book and pen
7. Watch with second hand

PROCEDURE

1. Upon admission, set up thermometer and holder at patient's unit:
    a. Fill thermometer holder (protective container from a 2 1/2 cc. disposable syringe) with disinfectant.
    b. Place thermometer inside container.
    c. Tape container to head of bed or side of bedside locker.
2. When taking temperatures:
    a. Take containers for cotton balls to bedside.
    b. Tell patient what you are going to do.
    c. Remove thermometer from holder.
    d. Wipe thermometer with clean cotton ball. Discard cotton ball in waste container.
    e. Shake down thermometer mercury to 95° F.
    f. Place thermometer under patient's tongue.
    g. Follow above steps to second and third patient.
    h. Take third patient's pulse and respiration. Record results in T.P.R. book.
    i. Take pulse and respiration of second patient, record, then first patient.
    j. Remove thermometer from first patient's mouth after 3 minutes.

TAKING ORAL TEMPERATURE (Continued)
INDIVIDUAL THERMOMETER TECHNIQUE

PROCEDURE (Continued)

2.
   - k. Wipe thermometer with clean cotton ball. Discard cotton ball in waste container.
   - l. Read thermometer and replace in holder. Record results in T.P.R. book.
   - m. Repeat steps j through l for second and third patient.

CARE OF EQUIPMENT

1. After each use:
   - a. Discard soiled cotton balls and container.
2. Weekly and when patient is discharged:
   - a. Collect thermometers and holders.
   - b. Disinfect thermometers as outlined on page 26.
   - c. Place in new holders containing disinfectant.
   - d. Discard old holders.
   - e. Replace thermometers and holders at bedside.

ADDITIONAL INFORMATION AT THIS ACTIVITY

TAKING TEMPERATURES WITH THE ELECTRONIC THERMOMETER

PURPOSE

To determine the patient's body temperature with an electronic thermometer which is a beat sending device with an accuracy of a plus or minus of .2 degrees. It utilizes a disposable probe cover and records oral and rectal temperatures within 15 seconds.

EQUIPMENT

1. Base for electronic thermometer
2. Thermometer with oral probe (sensing device)
3. Rectal probes where applicable
4. Disposable probe covers

PROCEDURE

1. Remove probe from base which is connected to electricity.
2. Attach strap of thermometer around shoulder to secure thermometer to side (left side if right handed).
3. Remove probe and insert probe into disposable probe cover.
4. Turn thermometer on by pressing small bar on top.
5. Place covered probe into patient's mouth in the sublingual area and slowly push probe along the base of the tongue as far back as possible without discomfort to the patient.
6. Hold probe in place until indicator on thermometer records a completed thermometer reading.
7. Transfer reading to appropriate records.
8. Eject the disposable probe cover.
9. Press bar on back of thermometer erasing present reading and repeat the above procedure for the next patient.
10. Remove thermometer pack and replace securely in base for recharging thermometer.

TAKING TEMPERATURES WITH THE ELECTRONIC THERMOMETER (Continued)

POINTS TO EMPHASIZE

1. Grasp probe at reinforced area in the center to decrease breakage.
2. Always keep base plugged into electrical current.
3. Always keep thermometer in base when not in use to keep the battery charged.
4. Use specified probe for rectal temperature and insert probe cover 1/2 inch on adults or 1/4 inch on babies for accurate recordings.
5. For axillary temperatures do not press bar to activate thermometer until the oral probe with cover is in place, then allow 60-90 seconds for recording of temperature. Indicator will not come on.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TAKING AXILLARY TEMPERATURE

PURPOSE

To determine a patient's temperature when the oral or rectal route is contraindicated.

EQUIPMENT

Oral thermometer tray
T.P.R. book
Pencil or pen
Watch with a second hand

PROCEDURE

Same as for oral temperature (pages 25 and 26) except:

1. Wipe axilla dry.
2. Place oral thermometer in axilla. Have patient cross arms over chest.
3. Leave thermometer in place for 10 minutes.
4. Write "A" above temperature in T.P.R. book, and T.P.R. graph (SF 511).

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TAKING RECTAL TEMPERATURE
THERMOMETERS DISINFECTED ON WARD

PURPOSE

To determine patient's temperature when the oral method is contraindicated.

EQUIPMENT

1. Tray containing
   - a. Two containers of disinfecting agent marked #1 and #2
   - b. Container of green soap solution
   - c. Container of water
   - d. Container of clean cotton sponges
   - e. Container for waste cotton sponges
   - f. Minimum of 4 thermometers in container #1 of disinfecting agent. (Number of thermometers determined by ward needs).
   - g. Tube of water soluble lubricant
   - h. T.P.R. book
   - i. Pencil and pen
   - j. Watch with second hand

PROCEDURE

1. Take equipment to bedside.
2. Tell patient what you are going to do.
3. Remove thermometer from container #1.
4. Wipe thermometer (over waste container) with water moistened sponge from stem to bulb using a rotary motion. Discard sponge in waste container.
5. Shake thermometer mercury to 95° F.
6. Lubricate thermometer with water soluble lubricant.
7. Turn patient on side unless contraindicated.
8. Separate buttocks and gently insert thermometer 1 1/2 inches into the rectum in an upward and forward direction. Insert 1/2 - 3/4 inch in infants and children.
9. Hold thermometer in place for 5 minutes. Count pulse and respiration and record in T.P.R. book.
10. Remove thermometer.

TAKING RECTAL TEMPERATURE (Continued)
THERMOMETERS DISINFECTED ON WARD

PROCEDURE (Continued)

11. Wash thermometer (over waste container) with soap moistened sponge from stem to bulb using rotary motion. Discard sponge in waste container.
12. Moisten cotton sponge with water and wipe thermometer from stem to bulb in a rotary motion. Discard sponge in waste container.
13. Read thermometer and record temperature in T.P.R. book. Place "R" above recording to indicate that it was taken rectally.
14. Return thermometer to glass #2 for sterilization for a minimum of 20 minutes.
15. Leave patient in comfortable position.
16. Record T.P.R.'s on SF 511. Use "R" to indicate rectal temperature.
17. Continue taking additional rectal temperatures in the same manner.

CARE OF EQUIPMENT

1. After each use
   a. Remove waste.
   b. Clean tray.
   c. Transfer thermometers from container #2 to container #1 after 20 minutes has elapsed.
   d. Replace water and soap solution.
   e. Reset tray.
2. Daily
   a. Wash containers in warm, soapy water, rinse and dry.
   b. Change all solutions.
   c. Wash thermometers in cold, soapy water, rinse well and place in disinfectant agent.
   d. Refill and reset tray.

POINTS TO EMPHASIZE

1. Wait 30 minutes before taking temperature on patient who has had an enema.
2. Use only a stub bulb thermometer expressly made for rectal use.
3. Do not leave patient unattended while thermometer is inserted.

TAKING RECTAL TEMPERATURE (Continued)
THERMOMETERS DISINFECTED ON WARD

POINTS TO EMPHASIZE (Continued)

4. Report abnormal vital signs to Charge Nurse.
5. Describe the quality of pulse and respirations in observation column on Nursing Notes (SF 510). On wards where many rectal temperatures are taken, (for example, Pediatrics, ICU, etc.), increase the number of thermometers in each container. Continue using thermometers from alternate containers, allowing at least 20 minutes for sterilization, until all patients' temperatures are taken.
6. Be sure to rinse thermometer well before putting it into the disinfectant, as bacterial action is nullified in the presence of soap - for example, Zephiran chloride and iodine preparations.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TAKING RECTAL TEMPERATURE (Continued)
THERMOMETERS DISINFECTED IN CENTRAL SUPPLY ROOM

EQUIPMENT

1. Tray containing
   a. Container of rectal thermometers sealed in paper envelopes
   b. Container of clean cotton sponges
   c. Container of soap solution
   d. Container for waste cotton sponges
   e. Container for used thermometers
   f. Tube of water soluble lubricant
   g. T.P.R. book
   h. Pencil or pen
   i. Watch with second hand

PROCEDURE

1. Remove thermometer from envelope.
2. Take, record and report vital signs as in previous procedure page 30.
3. Return thermometer to container of soap solution for return to C.S.R.

CARE OF EQUIPMENT

1. After each use
   a. Remove waste
   b. Clean tray
2. Daily
   a. Return container of thermometers to C.S.R. in accordance with local instructions and exchange for supply of sterile thermometers.
   b. Wash containers in warm, soapy water, rinse and dry.
   c. Refill and reset tray.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TAKING PULSE AND RESPIRATION

PURPOSE

To determine the character and rate of the pulse and respiration.

EQUIPMENT

Watch with a second hand
Pencil or pen
T. P. R. book

PROCEDURE

1. Tell patient what he is to do.
2. Have the patient lie down or sit in chair. Draw his arm and hand across his chest.
3. Place three fingers over the radial artery on the thumb side of the patient's wrist. Use just enough pressure to feel the pulse beat.
4. Observe the general character of the pulse, then count the number of beats for 30 seconds, multiply by two. If any deviation from normal or irregularity is noted, count for one full minute.
5. With the fingers still on the wrist, count the rise and fall of the chest or upper abdomen for 30 seconds, multiply by 2. If any irregularity or difficulty is noted, count for one full minute.
5. Record in T. P. R. book and report any abnormality.

POINTS TO EMPHASIZE

DO NOT use thumb when taking pulse beat.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

APICAL-RADIAL PULSE

PURPOSE

To compare the pulse rate of the heart at the apex and the pulse rate in the radial artery.

EQUIPMENT

Stethoscope
Watch with second hand

PROCEDURE

1. Tell patient what you are going to do.
2. Have patient lie quietly in bed.
3. Open pajama coat to expose chest.
4. One person standing on the left side of the bed places a stethoscope over apex of heart (slightly below and to the right of the left nipple) to locate the apical heart beat.
5. Another person standing on the right side of bed locates the radial pulse; hold watch so that it can be seen by both people.
6. Using the same watch and at a signal from the person taking the apical pulse, both people count for one minute.
7. Replace pajama coat; leave patient comfortable.
8. Record in observation column on Nursing Notes (SF 510). Example: Apical 92. Radial 86.

POINTS TO EMPHASIZE

Two corpsmen are necessary to carry out this procedure because the two pulses must be taken at the same time to compare rates.

CARE OF EQUIPMENT

1. Wipe earpieces and diaphragm/bell of stethoscope with alcohol sponges before and after procedure.
2. Return stethoscope to proper place.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TAKING BLOOD PRESSURE

PURPOSE

To determine the pressure which the blood exerts against the walls of the vessels.

EQUIPMENT

Sphygmomanometer
Stethoscope
Pencil and paper
Alcohol sponges

PROCEDURE

1. Tell patient what you are going to do.
2. Place patient in comfortable position sitting or lying down.
3. Place rubber portion of cuff over the brachial artery. Secure either by hooking or wrapping depending on the type of apparatus.
4. Clip indicator to cuff (aneroid) or place apparatus on a level surface (mercury) at about heart level. Make sure the tubing is not kinked and that it does not rub against the apparatus.
5. Locate brachial pulse at bend of elbow.
6. Place stethoscope in ears with ear pieces pointing forward.
7. Hold stethoscope in place over the brachial artery. Inflate cuff until the indicator registers 200 mm. Loosen thumb screw of valve and allow air to escape slowly.
8. Listen for the sounds. Watch the indicator. Note where the first distinct rhythmic sound is heard. This is the Systolic Pressure.
9. Continue releasing air from the cuff. Note where sound changes to dull muffled beat. This is the Diastolic Pressure.
10. Open valve completely. Release all air from cuff.
11. Remove cuff. Record reading.

TAKING BLOOD PRESSURE (Continued)

POINTS TO EMPHASIZE

1. Either arm may be used in taking blood pressure, but in repeating readings, it is important to use the same arm.
2. Some departments in the hospital may define diastolic pressure as the last sound heard.
3. If unsure of reading, completely deflate cuff and repeat procedure.

CARE OF EQUIPMENT

1. Fold and replace cuff.
2. Wipe ear pieces and bell/diaphragm of stethoscope with alcohol sponge before and after procedure. Replace.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

RECORDINGS ON THE TEMPERATURE, PULSE, AND RESPIRATION FORM

PURPOSE

To keep an accurate and up-to-date record of the patient's cardinal or vital signs.

EQUIPMENT

Pen with black or blue-black ink
Standard Form 511, Temperature--Pulse--Respiration
Ruler
Addressograph plate

PROCEDURE

1. Complete identifying data in lower left corner of SF-511.
2. Fill in spaces as indicated in the heading by printing:
   a. Month
   b. Date of month.
   c. Hospital day.
   d. Postoperative or postpartum day.
   e. Hours T.P.R's are taken.
3. Using a small dot, record temperature and pulse in spaces corresponding vertically to hour and horizontally to scales on left side of form. Join dots of previous readings by drawing straight lines with ruler.
4. Print respiration rate in space indicated to correspond with date and hour taken.
5. Record blood pressure in space indicated to correspond with date and hour taken.
6. Record height and weight on admission in spaces provided. Repeated weight recordings are made to correspond with date and hour taken.

POINTS TO EMPHASIZE

1. For every four hour and twice a day temperature and pulse, record within dotted lines.
2. For four times a day temperature and pulse, record on dotted lines.
3. Blood pressures required more than twice a day should be graphed on a Plotting Chart (SF 512).

RECORDINGS ON THE TEMPERATURE, PULSE, AND RESPIRATION FORM (Continued)

POINTS TO EMPHASIZE (Continued)

4. Any pecularities of the patient that affects the temperature, pulse, or respiration, i.e.; drop in temperature due to medication; ongoing cooling procedure; and/or absences from ward, may be recorded in graphic column at the designated time.
5. Indicate method - if axillary or rectal is used.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

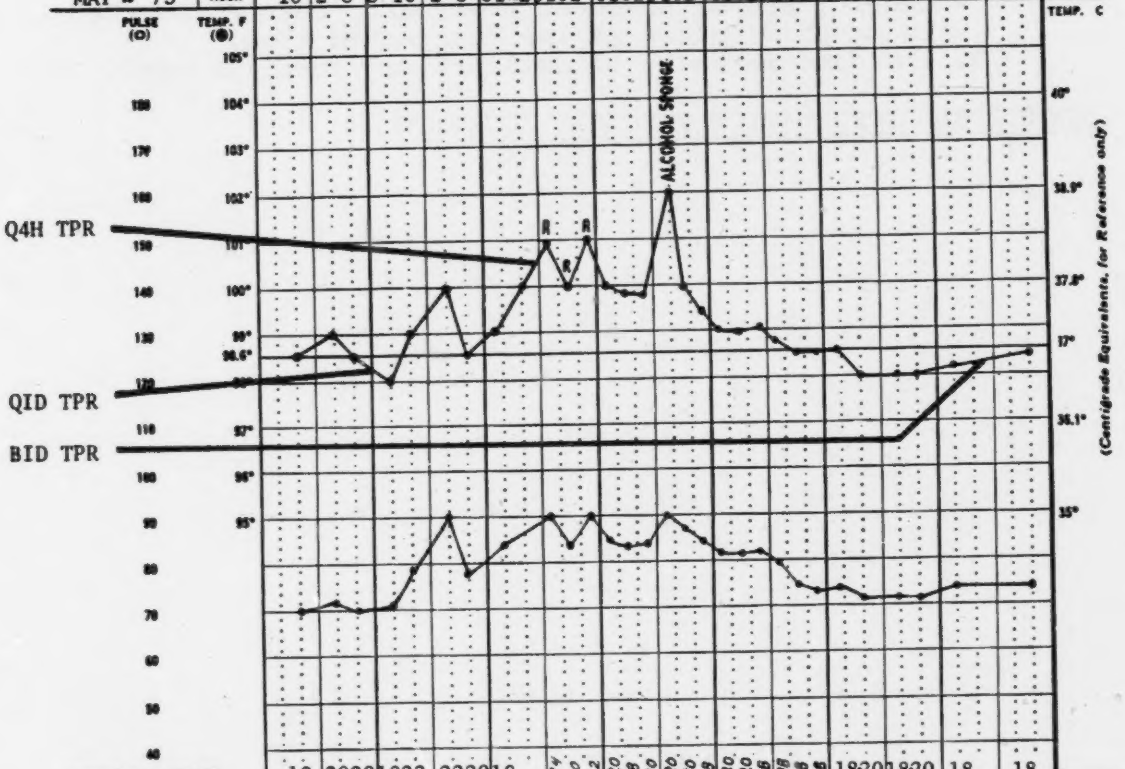
SAMPLE TEMPERATURE - PULSE -RESPIRATION (SF511)

Standard Form 511
Rev. August 1956
Bureau of the Budget
Circular A—33

CLINICAL RECORD

TEMPERATURE—PULSE—RESPIRATION
FAHRENHEIT

HOSPITAL DAY	1	2	3	4	5	6	7
POST- OP DAY			DOS	1	2	3	4
MONTH-YEAR / DAY	29	30	31	1	2	3	4
MAY 19 73 / HOUR	·10 2··6	6 10 2 6	6·10·2 6·10·2	6·10·2 6·10·2	6·10·2 6·10·2	6 10 2 6	6 6



RESPIRATION RECORD	18 2020	1822 2220	18 24 20 22	20 18 20 20 20 18	20 20 18 18 18 18	1820 1820	18 18

Record special data only when so ordered

BLOOD PRESSURE	120/80		128/86 - 130/86	124/84 120/84	120/80	For more frequent blood pressure recording use SF 512	
HEIGHT: 68 WEIGHT→	170						
Intake - 24 hr. total			3500	2800			
Oral			500	2800			
IV			3000				
Output - 24 hr. total			2950	2500			

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

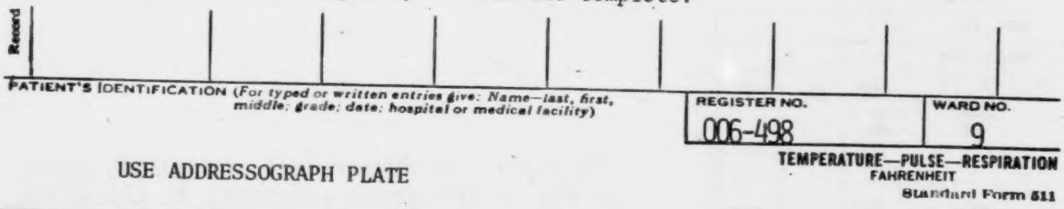
WARD NO.
9

USE ADDRESSOGRAPH PLATE

TEMPERATURE—PULSE—RESPIRATION
FAHRENHEIT
Standard Form 511
511-108

USING THE TEMPERATURE - PULSE - RESPIRATION GRAPHIC FORM 511

All entries shall be lettered in black or blue-black ink. Ballpoint pens may be used. Each sheet should have identifying data at the foot of each page. These data should be legible, correct and complete.



Record

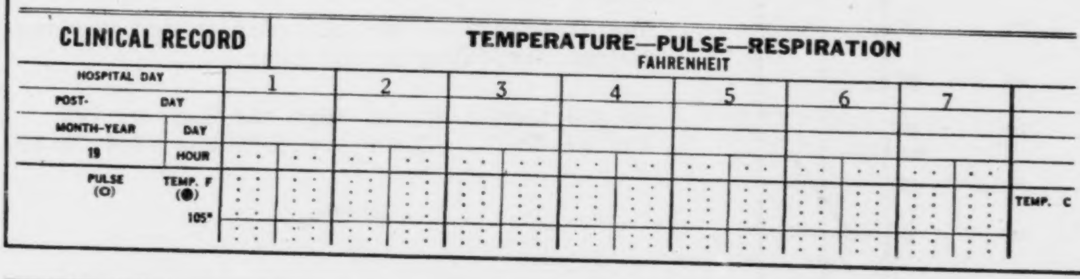
PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)

REGISTER NO.	WARD NO.
006-498	9

USE ADDRESSOGRAPH PLATE

TEMPERATURE—PULSE—RESPIRATION
FAHRENHEIT
Standard Form 511
511-108

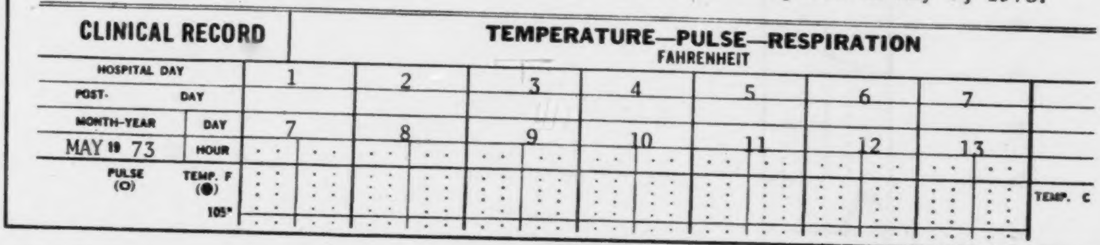
Each sheet is divided into seven major columns, one for each day of the week. The day of admission is the first hospital day.



CLINICAL RECORD — **TEMPERATURE—PULSE—RESPIRATION** FAHRENHEIT

HOSPITAL DAY	1	2	3	4	5	6	7	
POST- DAY								
MONTH-YEAR / DAY								
19 / HOUR								
PULSE (O) / TEMP. F (●)								TEMP. C
105°								

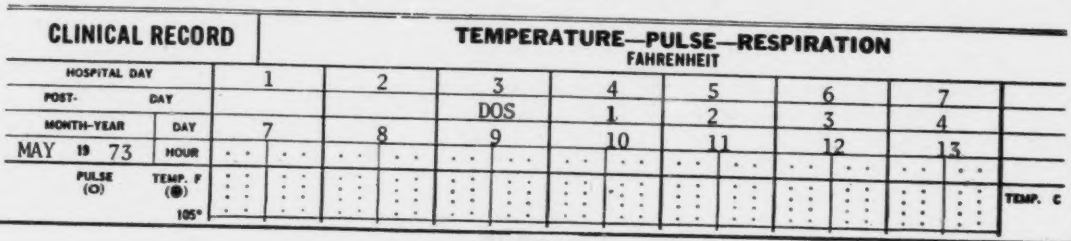
The month, day of the month, and year appear in the spaces for that purpose. In the sample below, the patient was admitted to the hospital on May 7, 1973.



CLINICAL RECORD — **TEMPERATURE—PULSE—RESPIRATION** FAHRENHEIT

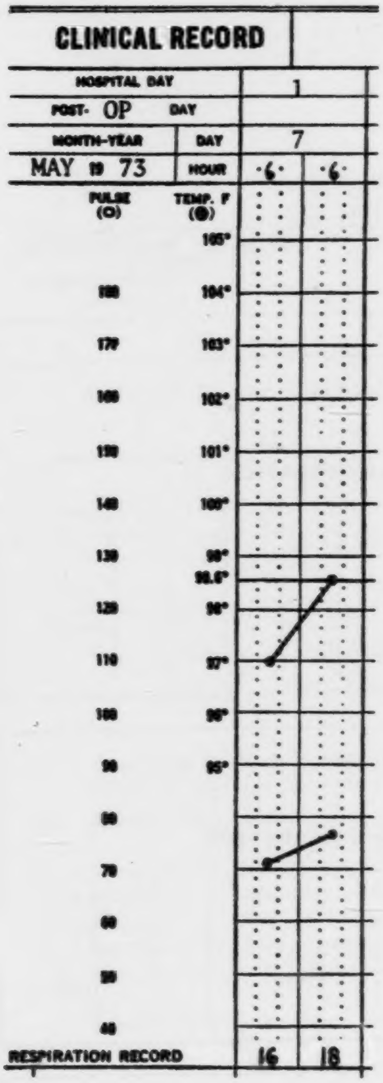
HOSPITAL DAY	1	2	3	4	5	6	7	
POST- DAY								
MONTH-YEAR / DAY	7	8	9	10	11	12	13	
MAY 19 73 / HOUR								
PULSE (O) / TEMP. F (●)								TEMP. C
105°								

The day of operation or delivery is lettered "Operation" or "Delivery". The following day is the first postoperative or postdelivery day. For example, if the patient had surgery on his third hospital day, the chart would appear as follows:



CLINICAL RECORD — **TEMPERATURE—PULSE—RESPIRATION** FAHRENHEIT

HOSPITAL DAY	1	2	3	4	5	6	7	
POST- DAY			DOS	1	2	3	4	
MONTH-YEAR / DAY	7	8	9	10	11	12	13	
MAY 19 73 / HOUR								
PULSE (O) / TEMP. F (●)								TEMP. C
105°								

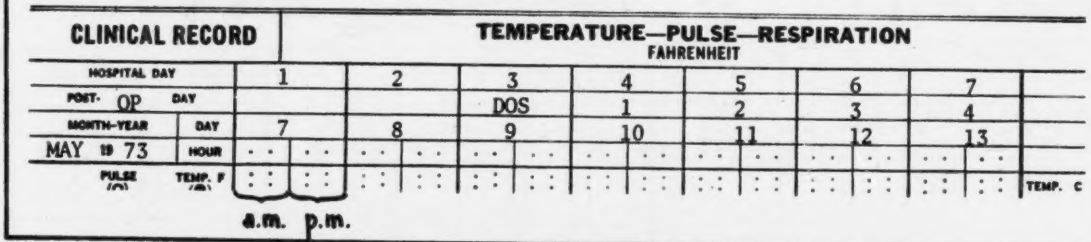


To chart the temperature and pulse, place a dot on the graph according to the scale on the left in the vertical column that designates the correct time and date. Connect the dot of the previous recording with a solid line.

The respirations are recorded in the vertical column according to the hour.

In the sample at the left the 6 a. m. TPR was 97-72-16. The 6 p.m. TPR was 98.6-76-18.

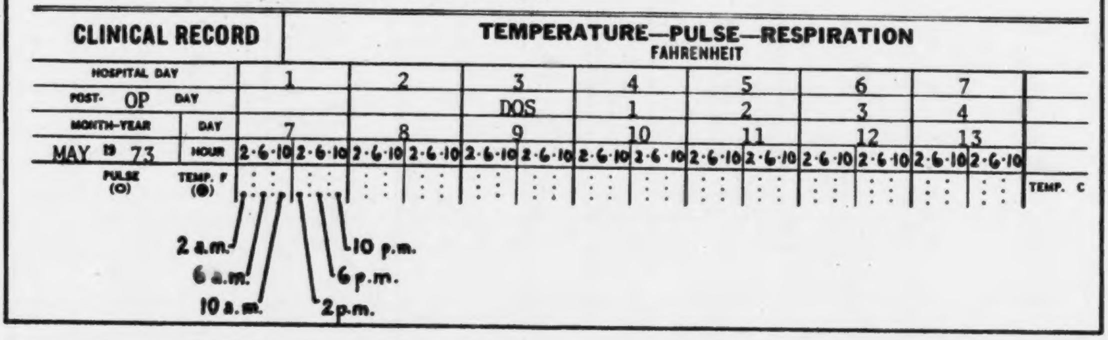
Each day is divided into two columns, a.m. and p.m.



CLINICAL RECORD — **TEMPERATURE—PULSE—RESPIRATION** FAHRENHEIT

HOSPITAL DAY		1		2		3		4		5		6		7		
POST- OP DAY						DOS		1		2		3		4		
MONTH-YEAR	DAY	7		8		9		10		11		12		13		
MAY 19 73	HOUR															
PULSE (O)	TEMP. F (●)															TEMP. C

The a.m. and p.m. subdivision is further divided by two vertical dotted lines. For every four hour temperature and pulse reading, place the recordings WITHIN the dotted lines.

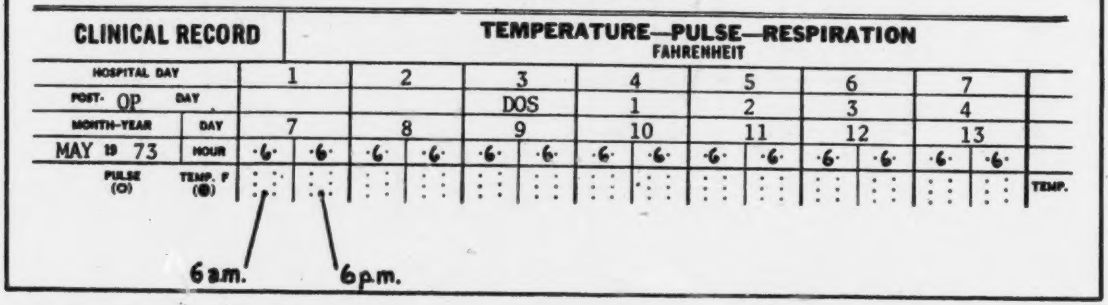


CLINICAL RECORD — **TEMPERATURE—PULSE—RESPIRATION** FAHRENHEIT

HOSPITAL DAY		1		2		3		4		5		6		7		
POST- OP DAY						DOS		1		2		3		4		
MONTH-YEAR	DAY	7		8		9		10		11		12		13		
MAY 19 73	HOUR	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	2·6·10	
PULSE (O)	TEMP. F (●)															TEMP. C

2 a.m.
6 a.m.
10 a.m.
2 p.m.
6 p.m.
10 p.m.

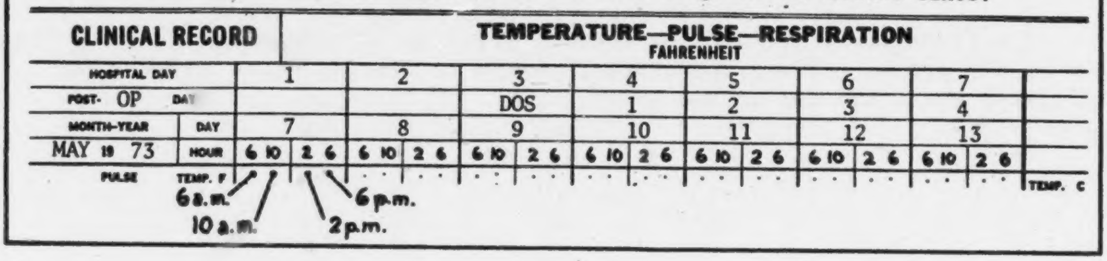
Twice a day temperature and pulse recordings are placed WITHIN the dotted lines in the center of the a.m. and p.m. column.



CLINICAL RECORD — **TEMPERATURE—PULSE—RESPIRATION** FAHRENHEIT

HOSPITAL DAY		1		2		3		4		5		6		7		
POST- OP DAY						DOS		1		2		3		4		
MONTH-YEAR	DAY	7		8		9		10		11		12		13		
MAY 19 73	HOUR	·6·	·6·	·6·	·6·	·6·	·6·	·6·	·6·	·6·	·6·	·6·	·6·	·6·	·6·	
PULSE (O)	TEMP. F (●)															TEMP.

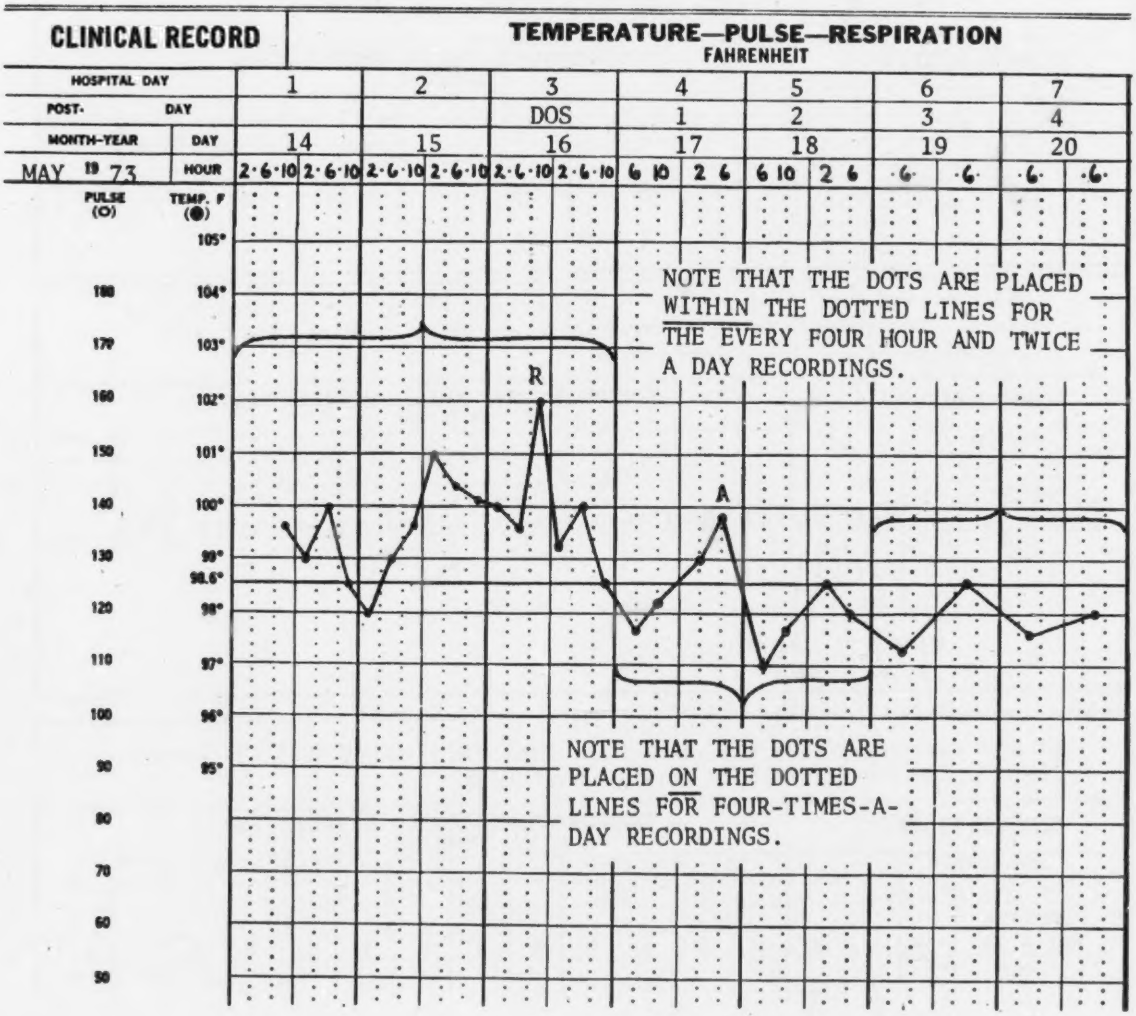
For four-times-a-day readings, place the recordings ON the dotted lines.



CLINICAL RECORD — **TEMPERATURE—PULSE—RESPIRATION** FAHRENHEIT

HOSPITAL DAY		1		2		3		4		5		6		7		
POST- OP DAY						DOS		1		2		3		4		
MONTH-YEAR	DAY	7		8		9		10		11		12		13		
MAY 19 73	HOUR	6 10	2 6	6 10	2 6	6 10	2 6	6 10	2 6	6 10	2 6	6 10	2 6	6 10	2 6	
PULSE	TEMP. F															TEMP. C

6 a.m.
10 a.m.
2 p.m.
6 p.m.



NOTE THAT THE DOTS ARE PLACED WITHIN THE DOTTED LINES FOR THE EVERY FOUR HOUR AND TWICE A DAY RECORDINGS.

NOTE THAT THE DOTS ARE PLACED ON THE DOTTED LINES FOR FOUR-TIMES-A-DAY RECORDINGS.

If a temperature is taken by rectum, place an "R" (for rectal) above the dot on the graph. If a temperature is taken by axilla, place an "A" (for axillary) above the dot on the graph.

RECORDING ON PLOTTING CHART

PURPOSE

To keep an accurate, visible record of repeated observations of intake-output, weight, blood pressure, etc.

EQUIPMENT

Pen with black or blue-black ink
Standard Form 512, Plotting Chart
Ruler

PROCEDURE

1. **Complete identifying data in lower left corner of chart. (Page 40)**
2. **Print date and purpose in upper left corner.**
3. **Calibrate measurements along vertical portion of graph:**
   a. **Start scale at bottom working toward top at a definite and uniform rate of progression, as 0-10-20. 30.**
   b. **Label scale at top to show unit of measure as cc., lbs., or mm.**
4. **Note date time intervals of measure along top horizontal portion of graph.**
5. **Show meaning of symbols used in a key to the side of graph.**

Note: **Red pencil may be used when filling in bar graphs.**

ADDITIONAL INFORMATION FOR THIS ACTIVITY

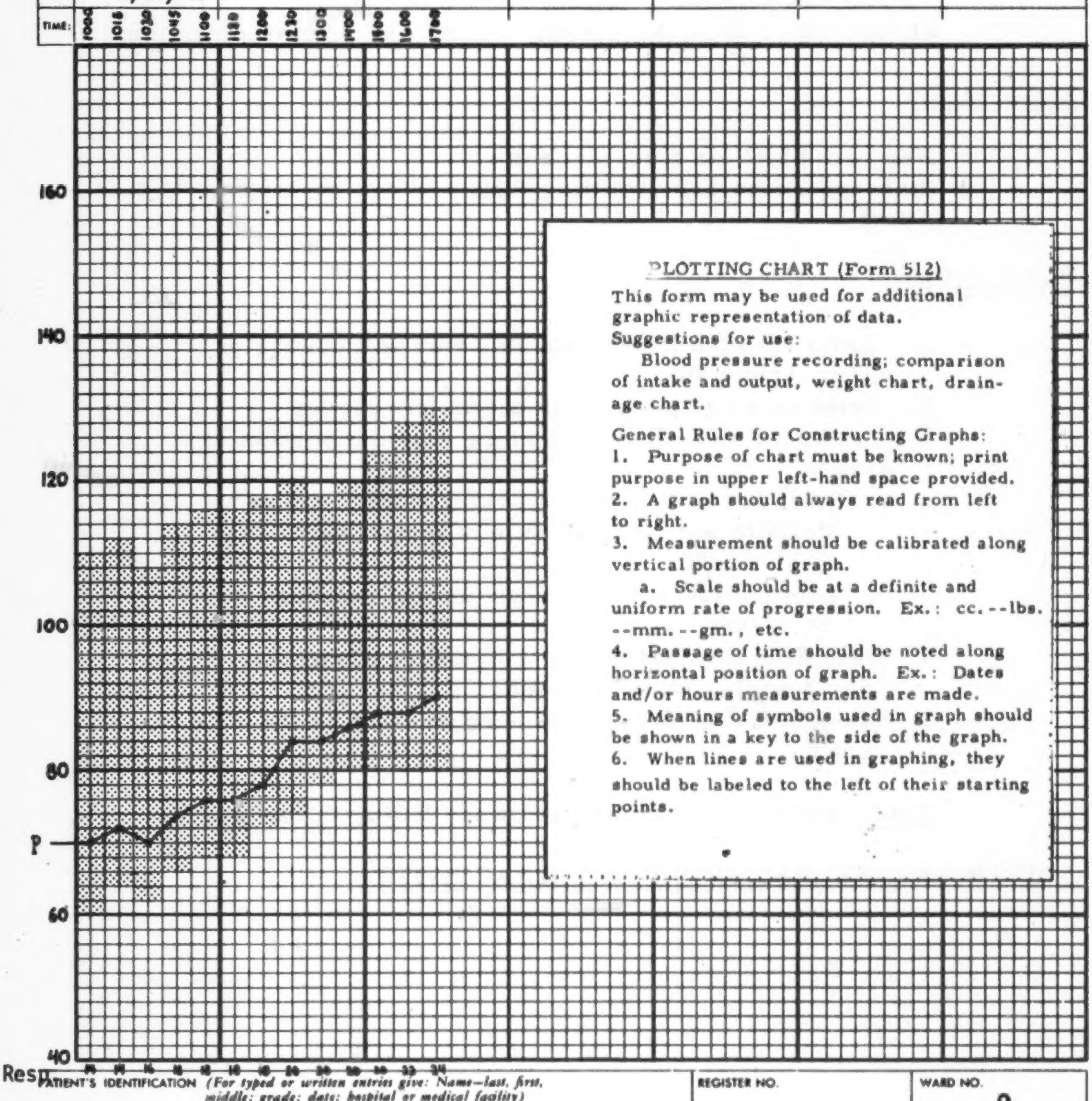
GPO : 1968 O—340-453 (50-J)

CLINICAL RECORD	**PLOTTING CHART**

TITLE OR PURPOSE OF GRAPH

BLOOD PRESSURE, PULSE, RESPIRATIONS, ON DAY OF SURGERY

DATE: 1/31/73



PLOTTING CHART (Form 512)

This form may be used for additional graphic representation of data.

Suggestions for use:

Blood pressure recording; comparison of intake and output, weight chart, drainage chart.

General Rules for Constructing Graphs:

1. Purpose of chart must be known; print purpose in upper left-hand space provided.
2. A graph should always read from left to right.
3. Measurement should be calibrated along vertical portion of graph.
   a. Scale should be at a definite and uniform rate of progression. Ex.: cc.--lbs.--mm.--gm., etc.
4. Passage of time should be noted along horizontal position of graph. Ex.: Dates and/or hours measurements are made.
5. Meaning of symbols used in graph should be shown in a key to the side of the graph.
6. When lines are used in graphing, they should be labeled to the left of their starting points.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO. 9

USE ADDRESSOGRAPH PLATE

STANDARD FORM 512
APRIL 1968
GENERAL SERVICES ADMINISTRATION &
INTERAGENCY COMM. ON MEDICAL RECORDS
FPMR 101-11.809-3
512-106

CARE OF THE SERIOUSLY ILL PATIENT

PURPOSE

To provide optimum care and close observation of the seriously ill patient.
To keep the patient mentally and physically comfortable.

EQUIPMENT

Special mouth care tray
Rubbing alcohol/skin lotion
Bed linen as necessary
Pillow and/or supporting appliances
Special equipment as needed:

  I.V. Standard
  Suction machine
  Oxygen
  Drainage bottles
  Intake and Output work sheet, DD Form 792

PROCEDURE

1. Place patient where he can be easily and closely observed.
2. Keep room quiet, clean and clear of excess gear.
3. Bathe patient daily and P.R.N.
4. Maintain good oral hygiene every 2-4 hours.
5. Wash, rub back and change position every 2 hours unless contraindicated.
6. Speak to patient in a calm, natural tone of voice even if he appears to be unconscious.
7. Report any sudden change in condition.
8. Keep an accurate intake and output record if ordered.
9. Offer fluids if patient is conscious and is able to take them.
10. Record and Report:
    a. Changes in T.P.R. and blood pressure.
    b. State of consciousness.
    c. All observations.

CARE OF THE SERIOUSLY ILL PATIENT (Continued)

POINTS TO EMPHASIZE

1. All patients are seen by a chaplain when they are placed on the Serious or Very Seriously Ill list.
2. Be considerate and kind to the patient's relatives.
3. Keep charting up-to-date.
4. Do not discuss patient's condition when the conversation might be overheard by the patient or unauthorized persons.
5. Refer all questions concerning the patient's condition to the doctor or nurse.
6. Be sure all procedures for placing a patient on the SL or VSL have been completed; for exmaple, inventory of personal effects and valuables.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREVENTION AND CARE OF DECUBITUS ULCER

PURPOSE

To maintain clean healthy tissues and promote optimum circulation to pressure areas.
To promote new growth of tissue to ulcerated areas.

EQUIPMENT

Basin of water
Soap
Washcloth and towel
Rubbing alcohol/lotion, cold cream, cocoa butter
Alternating pressure mattress (if available)

PROCEDURE

1. Inspect the skin of all bed patients frequently.
   a. Give special attention to areas over bony prominences and in the area of appliances.
   b. Report suspicious areas immediately.
2. Rub patient's back with skin lotion available at local command.
3. Change the patient's position every two hours unless contraindicated. Use alternating pressure mattress, if available.
4. If patient is incontinent:
   a. Answer patient's calls promptly.
   b. Bathe area thoroughly with soap and water and give back care each time he is soiled.
   c. Place on bedpan or offer urinal at frequent intervals.
5. If skin is broken:
   a. Wash with soap and water. Dry well.
   b. Massage the surrounding area.
   c. Relieve the pressure about the area.
   d. Apply medication or treatments as prescribed.

POINTS TO EMPHASIZE

1. Treatment of decubiti is dependent upon the order of the medical officer.

PREVENTION AND CARE OF DECUBITUS ULCER (Continued)

POINTS TO EMPHASIZE (Continued)

2. Do not use rubber rings or doughnuts for prolonged periods of time as they may tend to decrease the circulation to the affected parts.
3. Keep the patient dry and his bed free of wrinkles and crumbs.
4. Alternating pressure pad, Stryker frame, Foster Bed, or Synthetic Sheepskin Pad may be employed as adjuncts to nursing care.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ALTERNATING PRESSURE PAD

(Air Mattress)

PURPOSE

To aid in the prevention of decubitus ulcers and circulatory problems.

EQUIPMENT

Bed with mattress
Alternating pressure pad with motor assembly
Bed linen

PROCEDURE

1. Read instructions printed on flap at foot of pressure pad.
2. Explain equipment and its purpose to the patient.
3. Place alternating pressure pad over regular mattress, with air inlet tubes at foot of bed.
4. Tuck pad aprons under mattress at head and foot.
5. Place motor unit on floor at head of bed. Attach air inlet tubes to pump.
6. Connect pump to grounded electrical wall outlet.
7. Allow pad to inflate. Be sure that tubing is not kinked or pinched.
8. Cover pad with single sheet.
9. Transfer patient to bed. Complete bedmaking.

POINTS TO EMPHASIZE

1. Secure motor unit to cross bar under head of bed with hooks, when possible, to prevent pulling of inflow tubes when bed is moved.
2. Tuck flaps securely under mattress to prevent pad from sliding when either end of bed is raised.
3. Avoid kinks or twists in pad resulting from high Fowler's position for long periods of time.
4. Avoid use of pins, or other appliances that may puncture the pressure pad.
5. Do not use rubber sheets, other pressure pads, or air rings with alternating pressure pad.
6. Return to C.S.R. when not in use.

ALTERNATING PRESSURE PAD (Continued)

(Air Mattress)

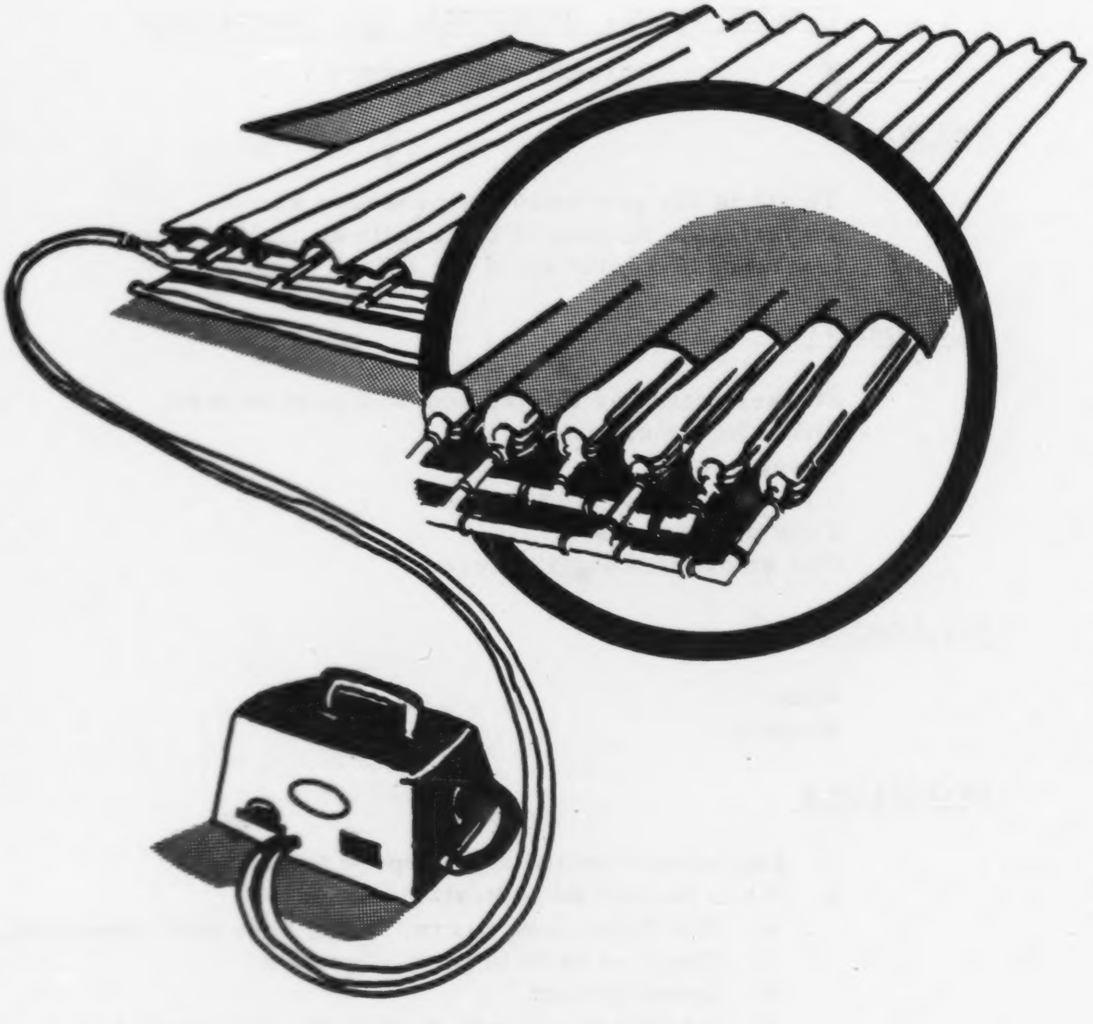
POINTS TO EMPHASIZE (Continued)

Note: Repair any punctures by deflating pad and applying pinhole sealer supplied with unit. Allow to set for four hours before inflating.

CARE OF EQUIPMENT

1. Disconnect unit from electrical circuit.
2. Detach inflow tubes from pump. Deflate pad and wash with soap and water or solution prescribed locally.
3. Do not autoclave.
4. Have Medical Repair check motor every two months.

ADDITIONAL INFORMATION FOR THIS ACTIVITY



ALTERNATING PRESSURE PAD

nms/mit

TURNING FRAME, ORTHOPEDIC BED (Continued)

(Stryker and Foster)

PURPOSE

To aid in the prevention of pressure areas.
To facilitate turning of burn patients and patients with fractures and injuries of the spinal column.

EQUIPMENT

Stryker frame or Foster bed with accessories.
Three heavy canvas straps
Three sheets
Four plastic covered pillows
Four pillowcases
One small pillow, if ordered

For Traction add

Rope
Weights

PROCEDURE

1. Explain procedure and purpose to patient.
2. Place patient on posterior frame:
   a. Use three-man carry. Keep body well supported.
   b. Place on back in good alignment.
   c. Cover patient.
   d. Insert arm boards in sockets on each side.
   e. Place pillows on arm boards. Small pillow under head, if ordered.
   f. Place foot support firmly against the feet.
3. Turning patient face down (use two men):
   a. Remove excess bed clothing.
   b. Remove small pillow from under head unless contraindicated.
   c. Place pillows lengthwise over patient.
   d. Remove arm boards and foot support.

TURNING FRAME, ORTHOPEDIC BED (Continued)
(Stryker and Foster)

PROCEDURE (Continued)

3.
- e. Position arms:
  - (1) Have patient grasp anterior frame with both hands after it has been applied, or
  - (2) Place arms at sides and secure by bringing draw sheet over arms and tucking under body.
- f. Disconnect drainage tubes and reconnect after turning.

STRYKER	FOSTER
g. Remove round nuts from pivot at head and foot.	g. Remove frame locking bar from head and foot assembly.
h. Place anterior frame snugly over patient. Replace and screw down round nuts securely.	h. Place anterior frame (turnbuckle with large loop) snugly over patient. Insert frame locking bars through corresponding holes in head and foot assembly.
i. Adjust face support.	i. Adjust head and chin support.
j. Buckle heavy canvas straps around both frames and patient at level of shoulders, hips and knees.	j. Buckle heavy canvas straps around both frames and patient at level of shoulders, hips and knees.
k. Tell patient when he is to be turned, and in what direction.	k. Tell patient when he is to be turned, and in what direction.
l. Pull out spring locks at center of each end. Turn patient over quickly and smoothly.	l. Unscrew safety lock at head end of frame. Turn patient over quickly and smoothly.

TURNING FRAME, ORTHOPEDIC BED (Continued)

(Stryker and Foster)

STRYKER	FOSTER
m. Check to see that spring locks have snapped into place by tipping frame back and forth gently once or twice, before releasing grasp on frame.	m. Tighten safety lock securely before releasing grasp on frame.
n. Remove canvas straps, round nuts and posterior frame.	n. Remove canvas straps, locking bars and posterior frame.
o. Replace round nuts on pivot at head and foot to prevent loss.	o. Replace locking bars in head and foot assembly to prevent loss.
p. Adjust face support. Pad if necessary.	p. Adjust head and chin support. Pad if necessary.
q. Insert arm boards. Place pillows.	q. Insert arm boards. Place pillows.
r. Adjust body in good alignment.	r. Adjust body in good alignment.
s. Cover patient with clean sheet folded lengthwise in half.	s. Cover patient with clean sheet folded lengthwise in half.

4. Turning patient from anterior to posterior frame (face up):

   a. Cover patient with clean sheets. Fold so that buttocks are exposed.
   b. Place pillows lengthwise over patient.
   c. Remove arm boards and pillows.
   d. Position arms:
      (1) Have patient grasp anterior frame with both hands after it has been applied, or
      (2) Place arms at sides and secure by bringing draw sheet over arms and tucking under body.
   e. Follow same steps as those for turning patient from posterior to anterior frame.

TURNING FRAME, ORTHOPEDIC BED (Continued)

(Stryker and Foster)

PROCEDURE (Continued)

5. Turning patient with I.V. fluids running:
   Move I.V. stand and solution to side to which patient is to be turned.
6. Turning patient with drainage or other tubes in place:
   a. If closed drainage system is used, leave tubes connected and clamp with hemostat or provided clamp.
   b. If tube must be disconnected before turning patient, clamp tube, disconnect and cover both open ends with sterile 4 x 4.
7. Use of bedpan:
   a. Remove center strip of canvas when patient is on posterior frame.
   b. Place bedpan on holder under frame.
8. Use of urinal:
   Slip urinal through opening from below when on anterior frame.
9. Application of traction with Crutchfield tongs:
   a. Tie rope to tongs.
   b. Pass rope through hole at end of frame and secure to frame standard, or attach weights.
   c. Obtain counter-traction, when ordered, by elevating foot frame.
   d. Turn patient without disturbing traction.

POINTS TO EMPHASIZE

1. Constant good body alignment is essential.
2. Before turning patient, clamp drainage tube to prevent backflow of drainage to cavity.
3. Unclamp and/or connect tubes after turning patient.
4. Make sure that wheels of frame are locked at all times, except when moving frame.
5. As an important safety measure, heavy web straps should be buckled around both frames and patient at levels of shoulders, hips, and knees.

TURNING FRAME, ORTHOPEDIC BED (Continued)

(Stryker and Foster)

POINTS TO EMPHASIZE (Continued)

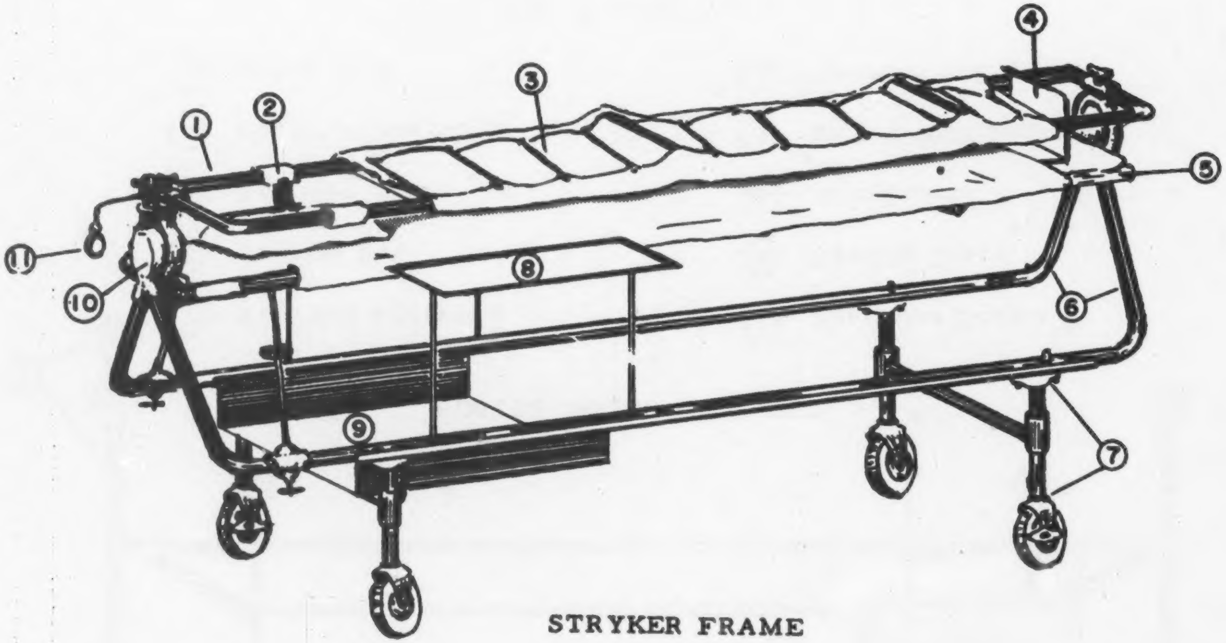
STRYKER	FOSTER
4. Check that spring locks catch after turning patient	4. Check that safety lock is tight after turning patient.
5. Replace round nuts on pivots to prevent loss.	5. Replace frame locking bars to prevent loss.
6. Prepare and maintain schedule for turning patient.	6. Increase or decrease hyperextension by adjusting large turnbuckle when ordered. Adjust frames to the identical curve of each other.

CARE OF EQUIPMENT

1. Strip frame of linen and canvas covers.
2. Remove any traction apparatus.
3. Wash down entire unit with soap and water.
4. Make up frames with padding and clean canvas.
5. Leave frame completely assembled with all attachments.
6. Check frame fasteners frequently.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

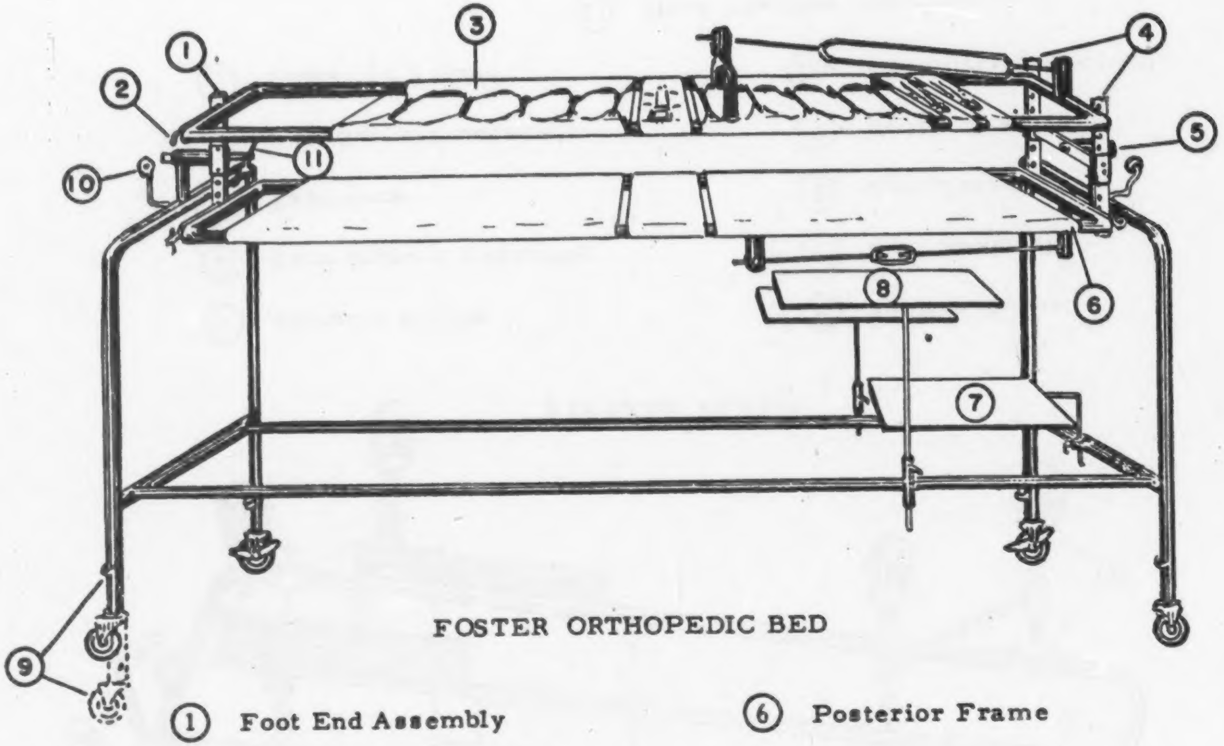
STRYKER FRAME



STRYKER FRAME

① Anterior Frame
② Face Support Assembly
③ Fasteners
④ Foot Support Assembly
⑤ Posterior Frame
⑥ Support Runner
⑦ Cart Assembly
⑧ Arm Board
⑨ Utility Tray
⑩ End Turning Assembly
⑪ Head Traction Attachment

FOSTER ORTHOPEDIC BED



FOSTER ORTHOPEDIC BED

① Foot End Assembly
② Locking Bar
③ Anterior Frame
④ Head End Assembly
⑤ Safety Lock
⑥ Posterior Frame
⑦ Reading Board
⑧ Arm Board
⑨ Caster With Lockpin
⑩ Traction Pulley
⑪ Traction Bar

CIRC-O-MATIC BED

(Circ-o-lectric Bed)

PURPOSE

To provide immobilization of body parts, when required, while permitting frequent change of position and facilitating administration of nursing care.

EQUIPMENT

Circ-o-lectric bed with accessories
Three restraining straps
Linen for bed

PROCEDURE

BED

1. Check springs holding the posterior and anterior frame covers.
2. Cover the foam mattress with plastic cover.
3. Place sheet over plastic mattress cover.

PATIENT

1. Explain to the patient what you are going to do.
2. Demonstrate, if possible, the functioning of the bed with a staff member in it before placing patient in bed.
3. Lock all casters to stabilize the bed during transfer.
4. Remove the anterior frame and set aside.
5. Adjust the posterior frame to the horizontal position.
6. Transfer patient to Circ-o-lectric bed.
    a. Use three-man carry. Keep body well supported.
    b. Place on back in good alignment with hips centered over the removable section of the posterior frame.

CIRC-O-MATIC BED (Continued)

(Circ-o-lectric Bed)

PROCEDURE (Continued)

TURNING PATIENT FROM SUPINE TO PRONE

1. Lock casters.
2. Make certain patient is lying with hips centered over removable section of posterior frame.
3. Place pillow lengthwise from ankles to knees, and a small pillow across abdomen.
4. Remove stud nut from bolt at head and foot of posterior frame.
5. Place the anterior frame over patient gently.
6. Adjust the face mask or the forehead band to the comfort of the patient.
7. Replace and screw down completely the stud nut at the head end.
8. Lift the foot end of the anterior frame to adjust the anterior footboard against the feet.
9. Lower the frame into place and screw the stud nut down completely at the foot end.
10. Place and secure the three 4" restraining straps around patient and frame at level of knees, hips and chest.
11. Instruct patient to "hug" anterior frame. If patient is unable to do so, secure arms at sides using restraining sheet.
12. Put the bed in motion gradually to prevent vertigo or loss of consciousness of patient.
13. When patient is in prone position:
    a. Remove restraining straps.
    b. Unscrew posterior nut from head end and push posterior frame upward until it locks into position.
    c. Replace stud nut.

THE FOOT END POSTERIOR STUD NUT IS NEVER REMOVED.

CIRC-O-MATIC BED (Continued)
(Circ-o-lectric Bed)

POINTS TO EMPHASIZE

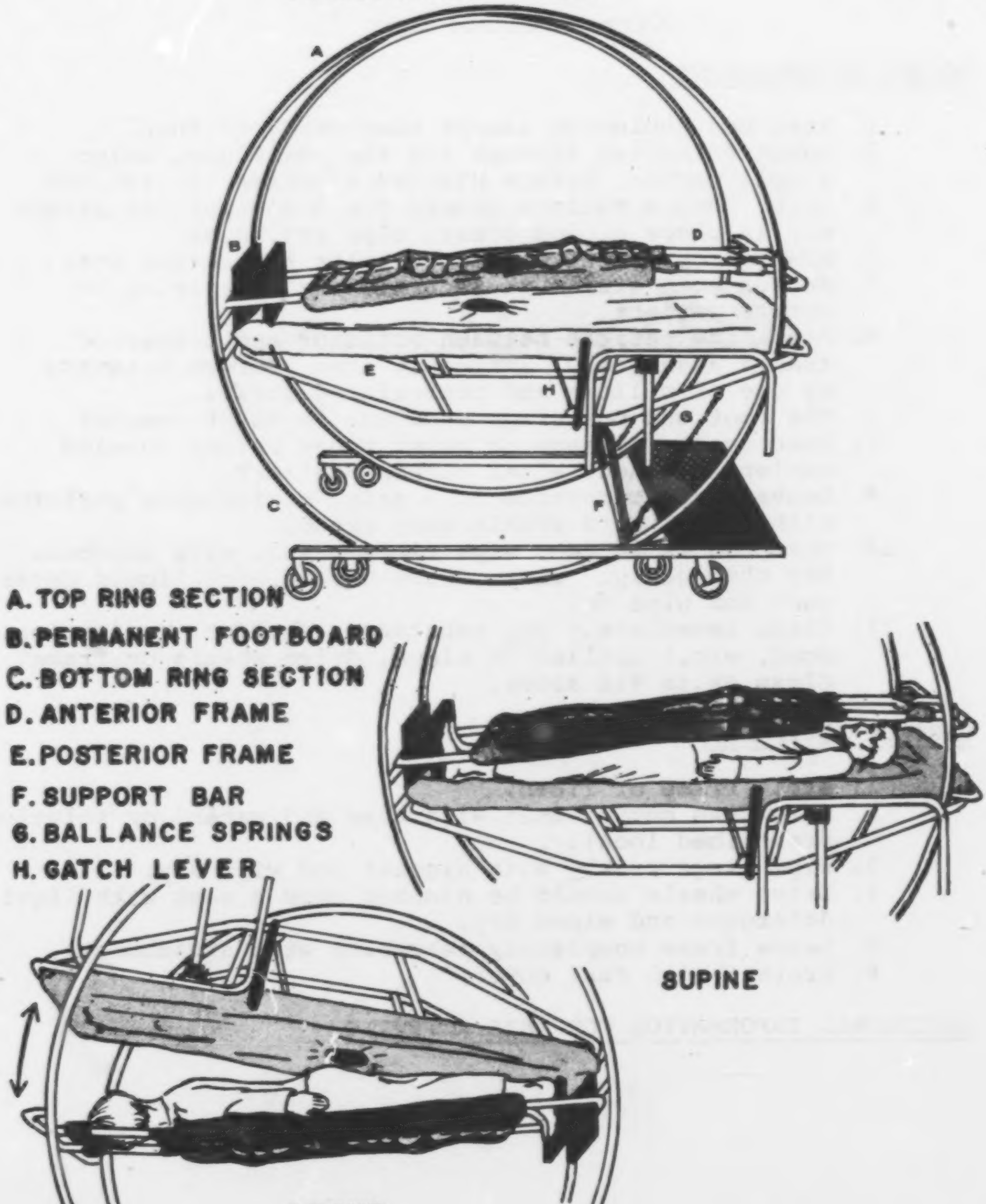
1. Keep bed unplugged except when ready to turn.
2. Operate the bed through all the positions, using a well person, before placing a patient on the bed.
3. Never turn a patient unless the 3 restraining straps are in place around chest, hips and knees.
4. Always replace stud nuts on bolts to prevent loss.
5. Fasten both stud nuts securely when preparing to rotate patient.
6. Stabilize patient between anterior and posterior frames adequately, including arms, before rotation by use of pillows and restraining straps.
7. The foot end posterior stud nut is NEVER removed.
8. Disconnect drainage or other tubes before turning patient. Connect after turning patient.
9. Leave patient covered in a safe, comfortable position with signal cord within easy reach.
10. When bed is in use, wipe rings weekly with alcohol. Dry thoroughly. Clean drive wheels with liquid detergent and wipe dry.
11. Clean immediately any substances (saline, medication, food, etc.) spilled on rings, drive wheels or frame. Clean as in #10 above.

CARE OF EQUIPMENT

1. Strip frame of linen.
2. Wash down entire unit with soap and water, or solution prescribed locally.
3. Wipe rings weekly with alcohol and wipe dry.
4. Drive wheels should be cleaned once a week with liquid detergent and wiped dry.
5. Leave frame completely assembled with attachments.
6. Protect with dust cover.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CIRCOMATIC BED


A
B
D
E
H
G
C
F
A. TOP RING SECTION
B. PERMANENT FOOTBOARD
C. BOTTOM RING SECTION
D. ANTERIOR FRAME
E. POSTERIOR FRAME
F. SUPPORT BAR
G. BALLANCE SPRINGS
H. GATCH LEVER
SUPINE
PRONE

ORTHOPEDIC TRACTION

SKELETAL TRACTION

Applied directly to the bone by tongs, pin, or wire connected to weights and pulleys.

PURPOSE

To maintain proper realignment of a fracture.
To immobilize an injury to the extremity.

EQUIPMENT

Bed with bed board under mattress
Balkan frame with trapeze
Splint
Foot plates
Rope
Pulleys
Weights and holder
Surgical instruments as requested by the doctor

PROCEDURE

1. Explain procedure and purpose to the patient.
2. Prepare bed with bed board, Balkan frame, and shock blocks if ordered by the doctor.
3. Shave and prepare skin as for a surgical procedure if ordered by the doctor.
4. Have necessary orthopedic equipment at bedside.
5. Assist the doctor as required.
6. Record time traction applied, by whom, amount of weights added, and patient's reaction on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. The angle of traction must be maintained. Shock blocks under the head or foot of the bed may be used to keep the patient in position.
2. The weight of traction must be maintained. Check weights frequently to observe that the weights are hanging free and the ropes are in the pulley grooves.
3. Check circulation in extremity every hour for first twenty four hours after application and every four hours thereafter.

ORTHOPEDIC TRACTION (Continued)

POINTS TO EMPHASIZE (Continued)

4. Maintain patient in good position at all tiems. Give skin care every 4-6 hours.
5. Steady weights when it is necessary to move bed.
6. Wires protruding from the sides of skeletal traction should be covered with corks.

CARE OF EQUIPMENT

When traction is discontinued, all parts are disassembled, cleaned, and returned to proper storage place.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ORTHOPEDIC TRACTION

SKIN TRACTION

Pulling device is attached to the skin with adhesive tape, adhesive moleskin, or special belts and halters.

PURPOSE

To promote and maintain alignment of fractured bones.
To relieve muscle spasm and pain.

EQUIPMENT

Wooden square with rope attached
Foam rubber strips, 3" wide
Moleskin, 3" wide
Ace bandage
Pulley
Weight holder
Weights
Equipment to shave skin
Tincture of benzoin

PROCEDURE

1. Explain procedure and purpose to patient.
2. Assemble equipment.
3. Shave skin if ordered by doctor.
4. Assist the doctor as required.
5. Record time traction applied and by whom, amount of weights added, and patient's reaction on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Change patient's position frequently to prevent development of decubiti.
2. Check weights frequently to observe that the weights are hanging free and the ropes are in the pulley grooves.
3. Check circulation in extremity every hour for first eight hours and every four hours thereafter.

ORTHOPEDIC TRACTION (Continued)

CARE OF EQUIPMENT

When traction is discontinued, all parts are disassembled, cleaned, and returned to proper storage place.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

BED OR HEAT CRADLE (Continued)

PURPOSE

To eliminate pressure from bed covers.
To carry out therapeutic application of heat.

EQUIPMENT

Bed cradle or heat cradle
String or gauze bandage

PROCEDURE

1. Assemble equipment. Tell the patient what you are going to do.
2. Place cradle over injured or affected area. Secure by tying to bed.
3. Arrange bedding neatly over frame.
4. Leave patient comfortable.

Heat Cradle:

1. Place 3-prong safety plug into grounded wall outlet.
2. Record date, hour, duration and effect of treatment on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Check the condition of the patient frequently when the treatment is instituted and periodically thereafter.
2. Check condition of equipment.
3. Select cradle of sufficient size to cover affected area and to permit patient to move.
4. Heat Cradle:
    a. The electric bulbs should be 25 Watts or less, covered with shields.
    b. Temperature may be regulated by turning bulbs on and off.
    c. Do not use with wet dressings.
    d. Only a 3-prong grounded electrical connection should be used.
5. Must have order for use.
6. Do not use with disoriented patients or children.

BED OR HEAT CRADLE (Continued)

CARE OF EQUIPMENT

1. Wash the cradle with soap and water or detergent and dry.
2. Return to C. S. R.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

POSTURE AND BODY MECHANICS

PURPOSE

To prevent fatigue, injury or strain to patient and/or staff member.

To Pull Up a Mattress

1. When patient is able to assist:
    a. Stand behind head of bed in proper position.
    b. Ask patient to flex his knees, feet flat on bed and grasp rungs at head of bed.
    c. Grasp underside of mattress with both hands.
    d. At signal, patient pushes with heels, corpsman flexes arms and shifts weight on feet to bring mattress to head of bed.
2. When patient is not able to assist:
    a. One corpsman stands on each side of bed facing head of bed.
    b. Grasp underside of mattress.
    c. At signal, shift weight on feet sliding the mattress to head of bed.

To Move a Patient From One Side of the Bed to the Other

1. Stand at side of bed toward which patient is to be moved.
2. Flex patient's knees with feet flat on bed.
3. Place one arm under patient's neck and shoulders, support his head with your arm.
4. Place other arm under small of patient's back.
5. Draw upper part of body to side of bed and remove arms from under patient.
6. Place one arm under lower part of back and other arm under thighs.
7. Draw lower part of body to side of bed.
8. Straighten bedding and leave patient comfortable.

POSTURE AND BODY MECHANICS (Continued)

To Move or Lift an Injured Arm or Leg

1. Have pillows in readiness to support extremity.
2. Place both hands beneath injured limb, at joints above and below site of injury. Raise slowly and gently.
3. Place extremity on pillow.

Note: Never pick up an extremity by grasping muscle groups. Always raise by holding at joint as ankle, knee, wrist, elbow.

To Help a Patient Sit Up in Bed

1. Face head of bed.
2. Slip arm under patient's armpit nearest you with flat of palm on patient's shoulder.
3. Tell patient to put his arm in same position on your shoulder.
4. Slip second arm around patient's neck and hold far shoulder with your hand so patient's head can rest in crook of arm.
5. At signal, both flex arms, shift weight on feet so you rock back bringing patient to sitting position.

To Move the Patient Up in Bed When He is Able to Assist

1. Lock wheels of bed.
2. Have patient flex knees and place feet flat on bed.
3. Patient places hands on your shoulders or grasps rungs at head of bed.
4. Place one arm under patient's shoulders and one under buttocks.
5. At signal, patient pushes with heels, straightens knees and flexes arms; you shift weight to forward foot and slide patient up in bed.

To Move a Helpless Patient Up in Bed

1. Two persons are required - "A" and "B".
2. Lock wheels of bed.
3. Flex patient's knees and ask patient to hold himself as rigid as possible.
4. "A" slips one hand under patient's head and shoulders and one arm under small of back.
5. "B" slips one arm just below "A"'s and one arm under patient's thighs.
6. "A" gives the signal and both slide patient up together by transferring weight from back to front of foot.

Note: Draw sheet may be used. Roll up sheet close to patient's sides. Patient may be moved up in bed in same manner as described above.

To Turn a Patient on His Side

1. Move patient over in bed away from the side he is to face when turned.
2. Roll patient over on his side toward you.
3. Flex underneath leg and hip slightly. Bring the upper leg forward to rest on a pillow.
4. Place pillow under head and neck.
5. Place a folded pillow in front of chest and at back if patient desires.

To Help Patient Sit Up on Side of Bed

1. Dress patient in pajamas.
2. Fanfold covers to foot of bed.
3. Bring patient to side of bed or place patient in sitting position on back rest.
4. Stand at side of bed. Put one arm under patient's shoulders and one arm under patient's knees which may be slightly flexed.
5. Have patient place his hands around your shoulders.

To Help Patient Sit Up on Side of Bed (Continued)

6. At signal, slowly straighten your knees, bringing patient to upright position.
7. Place stool or chair to support feet.
8. Place pillow behind patient's back for support and comfort.

To Help Patient Out of Bed to Chair

1. Sit patient on side of bed as above.
2. Note pulse rate and any untoward reactions to change of position.
3. Place chair in close proximity of bed.
4. Put bathrobe and slippers on patient.
5. Place hands under each of patient's axilla.
6. Have patient put his hands on your shoulders.
7. Allow patient to slide off bed and stand on floor.
8. Pivot with patient and support him as he sits down in chair.

Note: Remember to bend at the hips and flex your knees rather than bend at the waist.

To Move a Patient from the Bed to a Stretcher

1. Three-man carry:
    a. Stretcher is at right angle to foot of bed. Wheels locked.
    b. First man places one arm under patient's shoulders, supporting head on crook of arm with other arm under patient's back.
    c. Second man in center places arms under patient's back and thighs.
    d. Third man places arm under thighs and one arm under lower legs.
    e. At a signal from first man, patient is moved to side of bed.

POSTURE AND BODY MECHANICS (Continued)

To Move a Patient from the Bed to a Stretcher (Continued)

1.
    f. All men flex knees, forearms parallel to mattress and at given signal raise the patient, rolling him toward their bodies.
    g. Moving together, all three men walk to stretcher and lower patient onto stretcher.

2. Same procedure may be used to move a patient from stretcher to bed.

POINTS TO EMPHASIZE

1. Tell the patient exactly what is to be done and how he may help.
2. Be sure wheels of bed are locked.
3. Fold all bedding and clothing so patient will not be hampered by them and yet not be exposed.
4. Always face in the direction toward which the patient is to be moved.
5. Stand with feet apart, one foot in front of the other.
6. Tense abdominal muscles, flex knees, bend from the hips and keep the back straight.
7. Give most support to heaviest part of patient. Obtain help when moving a heavy or unmanageable patient.
8. Always slide rather than lift patient whenever possible.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

BODY POSITIONS OF THE BED PATIENT

PURPOSE

To maintain correct body alignment while confined to bed.

EQUIPMENT

Pillows
Foot Board
Covered sand bags
Rolled towel

PROCEDURE

1. SUPINE

a. Place patient flat on back with head, neck, and legs straight.
b. Feet should be braced against a foot board with toes pointed upward.
c. Heels should be positioned over the space between the mattress and the foot board.
d. The arms and legs may be supported with pillows and rolls as needed.

2. PRONE

a. Remove pillow and assist patient to turn on abdomen with head turned to one side.
b. Place arms above head or along side of body.
c. Place a flat pillow under the patient's abdomen for comfort. Be sure that the toes are suspended over the end of the mattress.
d. Use a large pillow under the legs to prevent toes from touching mattress.

BODY POSITIONS OF THE BED PATIENT (Continued)

PROCEDURE (Continued)

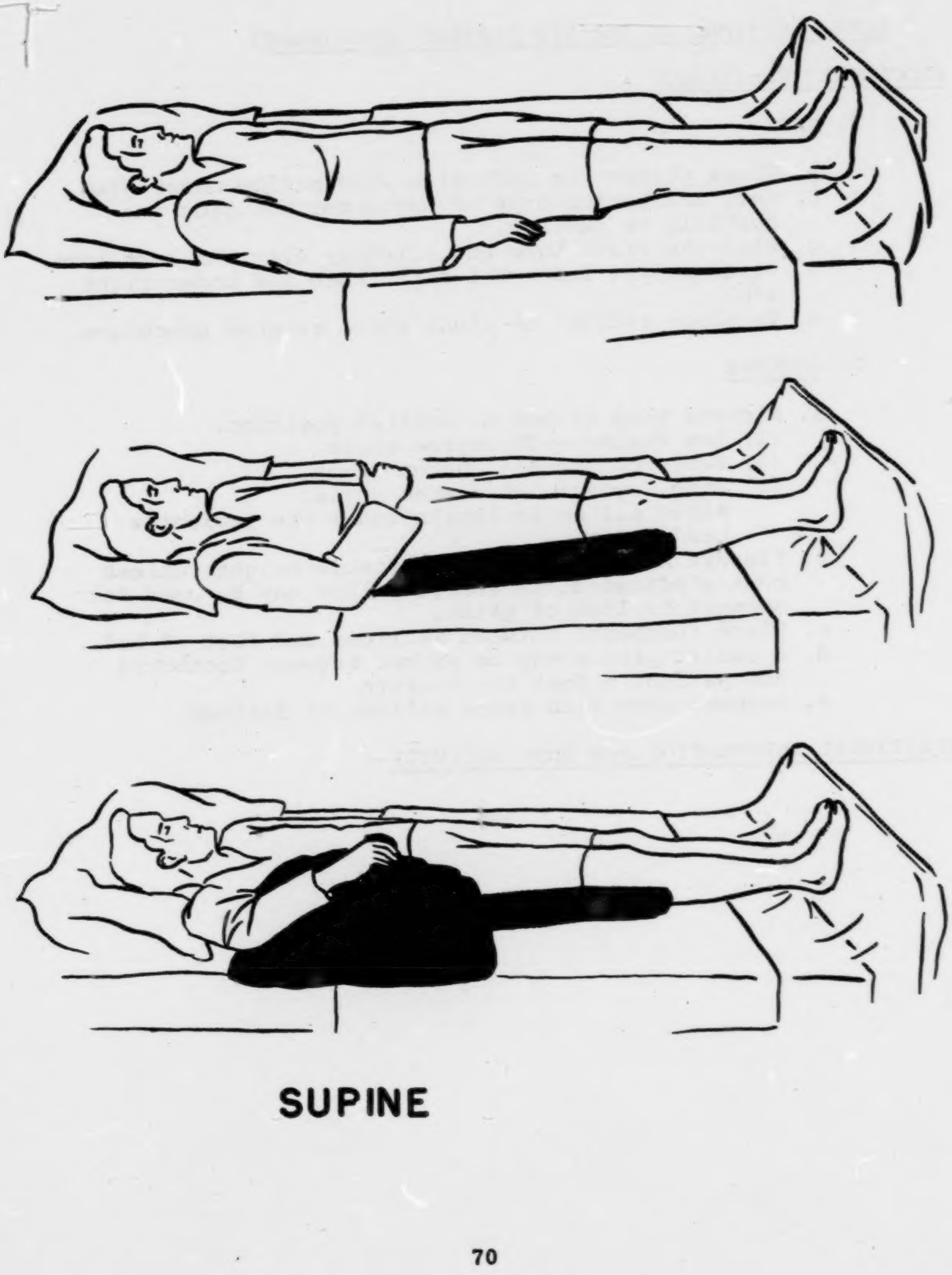
3. SIMS

   a. Place patient on left side with pillow under head.
   b. Left arm behind body or any other position comfortable to patient.
   c. Flex the right knee and slightly flex the left knee.
   d. Place pillow under the right knee and under right arm.
   e. To place patient on right side, reverse procedure.

4. FOWLERS

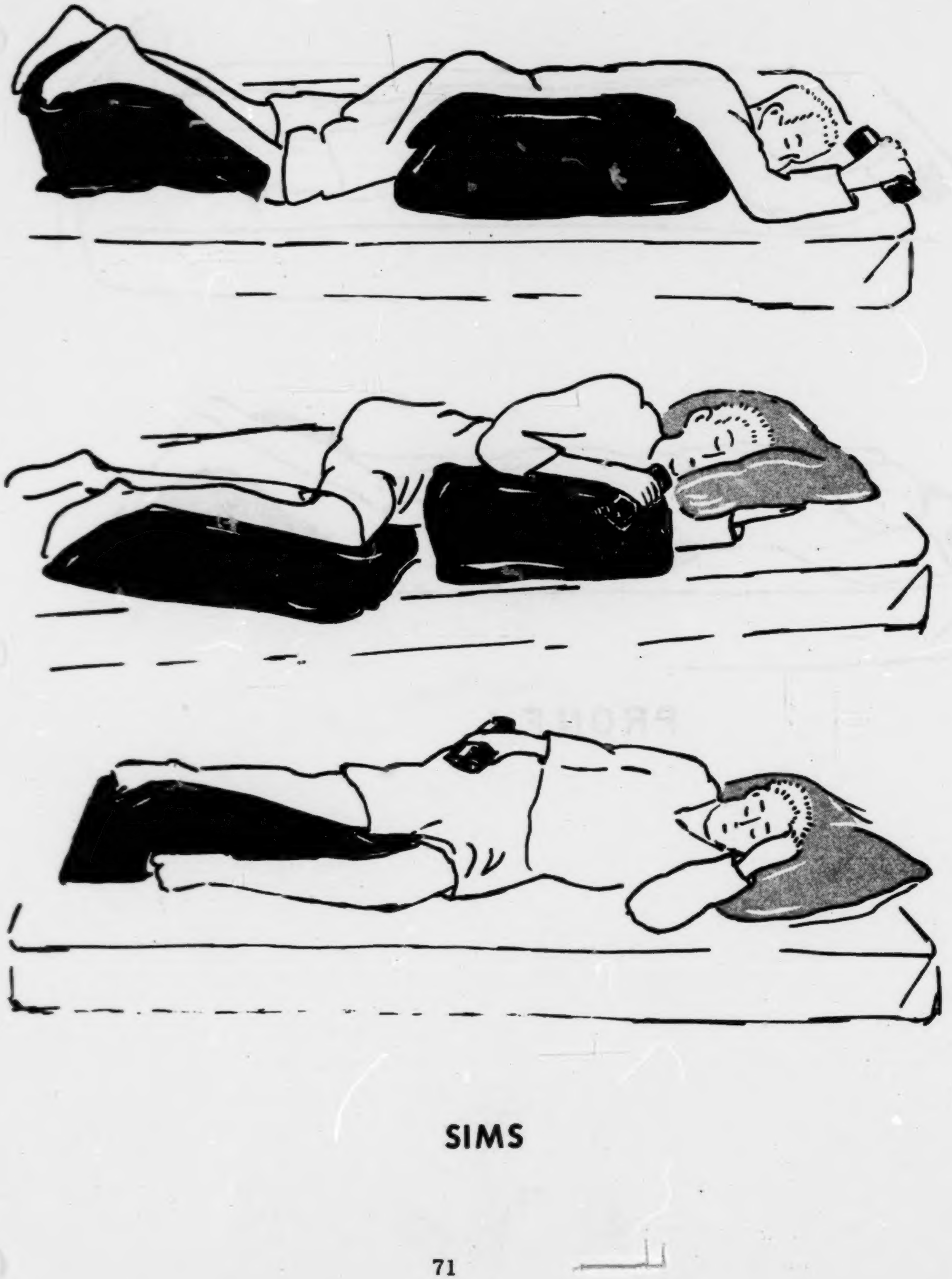
   a. Elevate head of bed to desired position.
      (1) Low Fowlers--30 degree angle.
      (2) Semi-Fowlers--60 degree angle.
      (3) High Fowlers--90 degree angle.
      Allow pillow to remain under the patient's head.
   b. Elevate knee gatch to comfortable height, unless contraindicated. A rolled pillow may be used for support in lieu of gatch.
   c. Place footboard between mattress and foot of bed.
   d. A rolled pillow may be placed between footboard and patient's feet for comfort.
   e. Support arms with extra pillows if desired.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

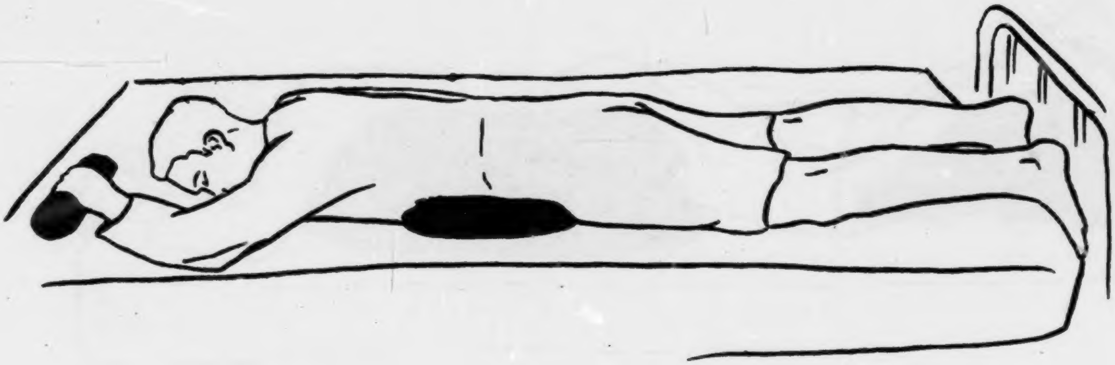


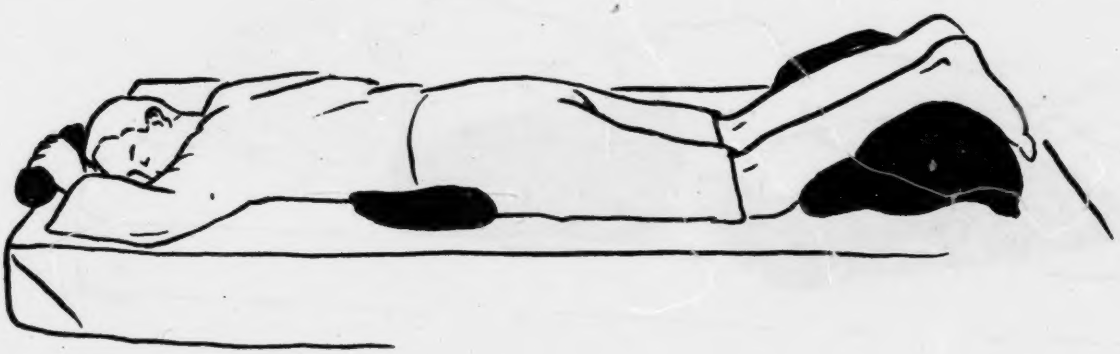
SUPINE

2



SIMS





PRONE

RECORDING NURSING NOTES

PURPOSE

To provide a clear, concise record of the patient's condition and progress throughout each twenty-four hour period.

EQUIPMENT

Pen with black or blue-black ink
Nursing Notes, Standard Form 510
Addressograph plate

PROCEDURE

1. Identifying information
   a. Stamp name, rate, etc. using addressograph plate in appropriate space at the bottom of the SF 510.
   b. When additional Nursing Notes, (SF 510), are required, insert in chronological order in back of completed Nursing Notes, (SF 510) and enter identifying information on each form.
2. Date and time
   a. Enter the date at midnight and at the beginning of each new page.
   b. Include hour with each new entry.
   c. Enter date and time of admission, and date and hour of discharge.
3. Entries in Observation Column
   a. Quality
      (1) All entries must be factual.
      (2) Each line of the observation section should be used.
      (3) All entries should be clear and concise.
      (4) All recording must be either legibly written or printed. Signature must be written and must include rate or rank.
      (5) Abbreviations used must be limited to those listed in this manual.
      (6) Each entry must be signed; if the same person has made several consecutive entries, only one signature is required.

RECORDING NURSING NOTES (Continued)

PROCEDURE (Continued)

3. b. Content
(1) Observations
(a) Objective Symptoms
1. Reaction to medication and treatment.
2. Changes in patient's physical and mental condition.
(b) Subjective Symptoms
1. Record patient's complaints in his own words, using quotations.
2. When interpreting subjective symptoms, qualify statement by "appears", "seems", etc.
(2) Nursing Procedures and Measures
(a) Describe all nursing care.
1. Nursing care administered and reaction of the patient to the care.
2. Special nursing measures such as alcohol sponge baths, special oral care, forcing of fluids, etc.
3. Specific nursing measures taken to protect patient and his property, such as application of restraints and securing of valuables.
(3) Medication, Treatments and Diets
(a) Single order for medication and/or treatment.
1. All medications are charted on the Medication Administration Record, including intravenous piggy-back medications contained in 100 cc of infusion. Intravenous infusion containing additive medications in total solution are recorded on the Nursing Notes.
2. Record patient's response to administered drugs, such as analgesics, tranquilizers, sedatives, anti-coagulants, antibiotics.
3. Record time treatment administered; type of treatment; if solution used, the amount; and patient's response to the treatment. Record signature at end of note.

PROCEDURE (Continued)

3. b. (3)

(b) Repeated or Running Order for diet or treatment.
  1. Chart all medications on the Medication Administration Record except those added to long term intravenous infusions, such as KCL and Berocea C.
  2. Record, first time of day given: name of diet, or type of treatment - manner of administration, as applicable - a listing of the hours to be given in the 24-hour period.
  3. If given at scheduled hours, draw a diagonal line through the hour and place initial above.
  4. If not given at scheduled hours, circle and initial hour. Record reason for omission in body of notes at appropriate hour.
  5. If discontinued, encircle hours, initial each, and enter "DC" at end of line.

(4) Tests and Examinations
  (a) All examinations, laboratory tests and diagnostic measures must be recorded in the observation column when they are accomplished.
  (b) Record the details of any test or examination performed and the response of the patient to it.

(5) Special reports made on a patient
  (a) If an accident or unusual happening occurs to a patient, record the time and how the event occurred, the effect on the patient, when notification of proper authorities was accomplished, and the time of examination by the physician. Record when a special report, such as "Accident Report" was completed and where it was sent.
  (b) If patient is placed on Serious List or Very Serious List, record time patient is placed on list, whether next of kin was present at bedside, whether the list was completed and forwarded to proper departments.

PROCEDURE (Continued)

3.b.

(6) Visits of Medical officers and others.
  - (a) Any visit of ward medical officer or any other medical or dental officer, other than at the routine ward rounds, must be noted and the time recorded.
  - (b) Any visit of chaplain other than a routine ward visit should be noted and the time recorded.
    - (1) Administration of religious rites to a patient must be noted along with the time administered and by whom they were given.
  - (c) Visits from others such as occupational therapist, physical therapist, dietitian, etc. should be noted.
  - (d) Personal visitors when significant (i.e. withdrawn patients or very seriously ill patients) should be noted and the patient's reaction to the visit.

(7) Absence of patient from the ward
  - (a) Note time of departure and return of patient:
    - 1. When taken to another ward or department for special tests or examination.
    - 2. When on authorized leave or liberty.
    - 3. When on unauthorized absence from ward.

POINTS TO EMPHASIZE

1. All nursing measures and treatments are charted after they are given.
2. Chart the diet as a single entry if the patient's reaction is of meaningful nature in determining prognosis.
3. Use only accepted abbreviations.
4. When an error is made, draw a straight line through the error and write "ERROR" above line. If for any reason a page must be copied, it must be marked "COPY" and the original is retained in the chart. No erasures are permitted. In either case, signature of person making correction is required.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SAMPLE CHARTING

NURSING NOTES

Standard Form 510
Rev. Feb. 1958
Bureau of the Budget
Circular A—32
Stock No. 1-0109-201-2304

CLINICAL RECORD | **NURSING NOTES** (Sign all notes)

DATE 1973	HOUR A.M.	 P.M.	OBSERVATIONS Include medication and treatment when indicated
16 JAN	0700		BLAND DIET TAKEN WELL. STATED, "I FEEL LIKE
			EATING NOW." Doris Black LT, NC, USN
	0810		COMPLETE BED BATH GIVEN. SEEMS TO TIRE
			EASILY UPON MOVING FROM SIDE TO SIDE. PLACED
			IN LEFT LATERAL POSITION WITH PILLOW TO
			SUPPORT BACK.
	0830		APPEARS CONCERNED ABOUT LIMITATION OF
			ACTIVITY ASKING, "WHEN CAN I TAKE CARE OF
			MYSELF?" David Quinn HN, USN
	0950		SICK CALL BY DR. DENNISH. Carol Smith LT, NC, USN
	1000		BETWEEN MEAL FEEDING HELD. PATIENT IS NPO
			FOR DUODENOSCOPY THIS AFTERNOON. HAS BEEN
			INSTRUCTED NOT TO EAT OR DRINK ANYTHING TILL
			AFTER STUDY IS COMPLETED. APPEARS TO BE
			RESTING COMFORTABLY NOW. J. Thomas HN, USN
		1300	TO X-RAY VIA GUERNEY FOR DUODENOSCOPY
		1410	RETURNED FROM X-RAY. STATES, "I FEEL SICK TO
			MY STOMACH." DR. DENNISH NOTIFIED.
			David Quinn HN, USN
		1430	SEEMS LESS UPSET NOW FOLLOWING VISIT OF
			DR. DENNISH. ANTACID GIVEN Doris Black LT, NC, USN

Continue on reverse side

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

WARD NO. 6

NURSING NOTES
Standard Form 510
510-107
PLATE NO. 10814 (REV.)

USE ADDRESSOGRAPH PLATE

TRANSCRIPTION OF DOCTOR'S ORDERS

PURPOSE

To ensure that the right patient receives the prescribed medication, treatments and tests.

EQUIPMENT

Nursing Care Plan I, NavMed 6550/1
White Medication and Treatment cards, NavMed 6550/4
Colored Medication and Treatment cards - PRN NavMed 6550/5
Medication and Treatment board
Standard Form 508, Doctor's Orders
Appropriate Standard Forms

PROCEDURE

1. Read order carefully and inquire if any doubt exists as to meaning or clarity of order.
2. If medication is ordered:
   a. For each stat, preoperative, or single dose medication:
      (1) Completely fill in white medication and/or treatment card (NavMed 6550/4) in the following order:
         (a) Last name, first name and middle initial.
         (b) Type of medication ordered and route of administration.
         (c) Dosage.
         (d) Date and time started.
         (e) Date and time to be discontinued, if so ordered.
         (f) Frequency and hours of administration.
         (g) Transcriber places his initials on upper right hand corner of medication card.
      (2) Sign your full signature, grade/rate, date, and hour in appropriate column of Doctor's Orders (SF 508) for each individual order that has been transferred and carried out. In a series of orders, initial each order as it is transcribed and record full signature, grade/rate, date, and hour at completion of series.
      (3) Place completed NavMed 6550/4 on medication board at the hour when treatment is due.

PROCEDURE (Continued)

2.
  b. For [illegible] PRN medication:
    (1) Completely fill in colored Medication and Treatment Card (NavMed 6550/5) in the following order:
      (a) Last name, first name, middle initial.
      (b) Medication and route of administration.
      (c) Dosage.
      (d) Date started.
      (e) Date to be discontinued.
      (f) Frequency medication may be safely given.
      (g) Transcriber places his initials on upper right hand corner of medication card.
    (2) Transcribe PRN medication onto Nursing Care Plan I (NavMed 6550/1) and Medication Administration Record.
    (3) Sign your full signature, grade/rate, date and hour in appropriate column of Doctor's Orders (SF 508) or your initial if part of a series of orders.
    (4) Place cards on board corresponding to hour when medication may be safely repeated, or on the PRN space.

3. If treatment or tests are ordered and:
  a. Must be carried out in another department -
    (1) Complete appropriate chits (blood, consultation, etc.) and send to appropriate department.
    (2) Sign your full signature, grade/rate, date, and hour in appropriate column of Doctor's Orders (SF 508) indicating that chits have been made out. In a series of orders, initial each order and use full signature only at completion of series.
    (3) Transcribe the treatment or test to the Nursing Care Plan I (NavMed 6550/1).
  b. Must be carried out on the nursing unit -
    (1) For recurring treatments and tests:
      (a) Completely fill in a white Medication and Treatment Card (NavMed 6550/4) in the following order:

TRANSCRIPTION OF DOCTOR'S ORDERS (Continued)

PROCEDURE (Continued)

3.b.(1) (a)
        1. Name - last, first and middle initial.
        2. Type of treatment or test ordered.
        3. Date and time started.
        4. Date and time to be discontinued, if so ordered.
        5. Frequency and hour of administration.
        6. Transcriber places his initials on upper right hand corner of medication card.

(b) Sign your full signature, grade/rate, date, and time in appropriate column of Doctor's Orders (SF 508) for each individual treatment or test order that has been transcribed. In a series of orders, inital each order as it is transcribed and record full signature, grade/rate, date, and time of completion of series.

(c) Place Medication and Treatment card (NavMed 6550/4) on medication board at the hour when treatment or test is due.

(d) Transcribe the treatment or test on to the Nursing Care Plan I (NavMed 6550/1).

(2) For PRN treatments or tests:

(a) Completely fill in colored Medication and Treatment card (NavMed 6550/5) in the following order:
        1. Name - last, first and middle initial.
        2. Type of treatment or test ordered.
        3. Date and time ordered.
        4. Date and time to be discontinued.
        5. Frequency the treatment may be safely administered.
        6. Transcriber places his initials on upper right hand corner of medication card.

(b) Sign your full signature, grade/rate, date, and hour in the appropriate column of the Doctor's Orders (SF 508) for each individual treatment or test order that has been transcribed. In a series of orders, initial each order as it is transcribed and record full signature, grade/rate, date, and hour at completion of series.

(c) Place Medication and Treatment card (NavMed 6550/5) on medication/treatment board at hour when the treatment may be safely repeated or on the PRN space.

PROCEDURE (Continued)

3.b.(2)

(d) Transcribe the treatment or test on to the Nursing Care Plan I (NavMed 6550/1).

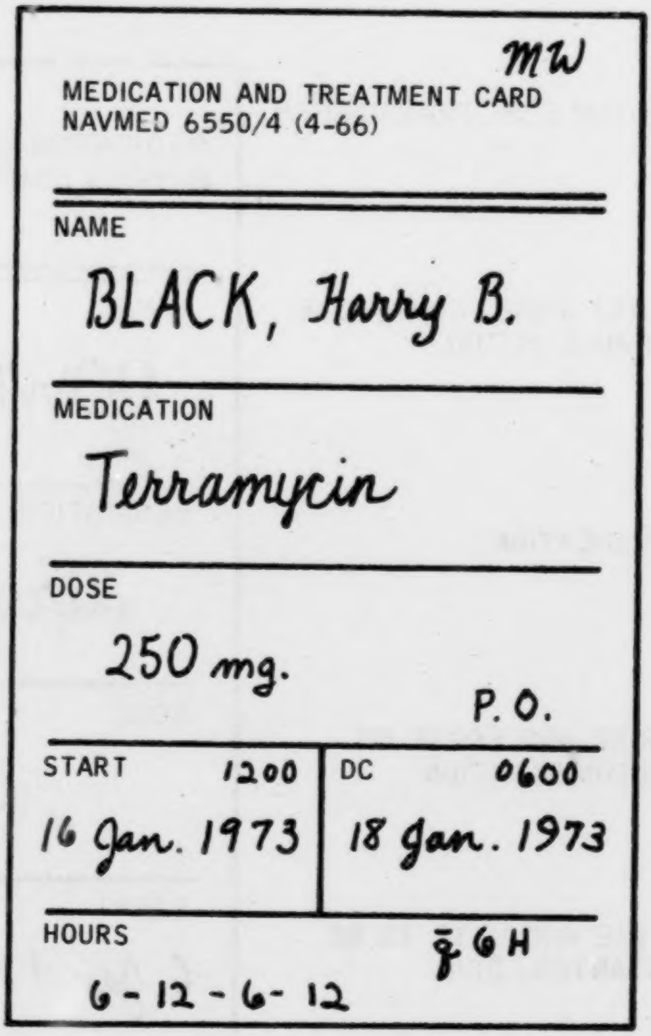
4. All stat or emergency medications, treatments and tests are carried out immediately after interpreting the order. When the procedure is completed, place your full signature, grade/rate, date, and hour in the appropriate column of the Doctor's Orders (SF 508) indicating that it has been carried out. Destroy Medication and Treatment card (NavMed 6550/4) after charting on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Check spelling of patient's name.
2. If unable to read order easily or if the dosage is questionable, check with doctor.
3. Check completed card with doctor's order before placing on medication board.
4. Orders transcribed by nonprofessional personnel are to be checked and countersigned by a registered nurse.
5. Enter the date and hour beside your signature on the Doctor's Orders (SF 508).

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ROUTINE MEDICATION CARD



INITIALS OF TRANSCRIBER	MW MEDICATION AND TREATMENT CARD NAVMED 6550/4 (4-66)
LAST NAME, FIRST NAME, MIDDLE INITIAL COMMON NAME REQUIRES MIDDLE NAME, OTHERWISE, WRITE INITIAL.	NAME BLACK, Harry B.
MEDICATION	MEDICATION Terramycin
DOSE AND ROUTE OF ADMINISTRATION	DOSE 250 mg. P.O.
TIME, DATE TO BE STARTED & DC'd -- USE PENCIL FOR DC TIME AND DATE. DC LEFT BLANK IF INDEFINITE	START 1200 16 Jan. 1973 DC 0600 18 Jan. 1973
FREQUENCY AND HOURS OF ADMINISTRATION	HOURS q̄ 6 H 6 - 12 - 6 - 12

PRE-OP MEDICATION CARD

INITIALS OF TRANSCRIBER	mw MEDICATION AND TREATMENT CARD NAVMED 6550/4 (4-66)
LAST NAME, FIRST NAME, MIDDLE INITIAL	NAME DOWNS, Thomas G.
MEDICATION	MEDICATION Atropine
DOSE AND ROUTE OF ADMINISTRATION	DOSE 0.4 mg. I.M.
TIME AND DATE TO BE STARTED, DC'd	START 6 Jan 1973 DC after giving
FREQUENCY AND TIME OF ADMINISTRATION	HOURS on call

PRN MEDICATION CARD

THIS CARD IS YELLOW

INITIALS OF TRANSCRIBER	MW	
	MEDICATION AND TREATMENT CARD NAVMED 6550/4 (4-66) **PRN**	
LAST NAME, FIRST NAME, MIDDLE INITIAL	NAME DOBBS, James F.	
MEDICATION	MEDICATION Demerol	
DOSE AND ROUTE OF MEDICATION	DOSE 75 mg I.M.	
TIME AND DATE TO BE STARTED. DC UNLESS ORDER RENEWED BY DOCTOR	START 16 Jan. 1973	DC 18 Jan. 1973
FREQUENCY OF ADMINISTRATION	HOURS $\bar{q}$ 4 h (for relief of operative pain.)	

RECORDING INTAKE AND OUTPUT

PURPOSE

To keep an accurate account of the patient's total intake and output.

EQUIPMENT

Pencil or pen
DD Form 792, Intake and Output Sheet
Equipment for measuring intake and output
"Intake and Output" sign

PROCEDURE

1. Insert identifying data in lower left corner of DD Form 792, using addressograph plate.
2. Fill in date and total number of hours covered in upper right corner.
3. Explain procedure and its importance to patient.
4. Place "Intake and Output" sign on bed.
5. Place intake and output form and pencil at bedside.
6. Record time and amount of all intake under proper heading:
   a. Fluids by mouth.
   b. Parenteral fluids.
7. Record time and amount of all output under proper heading:
   a. Urine.
   b. Drainage.
   c. Emesis.
   d. Stool.
8. Empty, measure and record contents of all drainage bottles at designated time.
9. Total all intake and output at designated time. Record totals on Nursing Notes (SF 510) and/or T.P.R. sheet (SF 511) as directed by local procedure.
10. Start new form at designated time.
11. DD-792 Forms should be discarded after discharge of patient.

RECORDING INTAKE AND OUTPUT (Continued)

POINTS TO EMPHASIZE

1. If intake is by tube, add (T) after entry.
2. If urinary output is by catheter add (C) after entry.
3. When parenteral fluid is being administered, include amount started initially under "intake" column; record only the amount actually received in the amount column.
4. Upon completion of 24 hour intake, enter absorbed amount of current intravenous infusion in amount column of Intake and Output Sheet being totaled. Enter type and amount of solution remaining in current infusion in Intake Column of new form.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SAMPLE

NURSING SERVICE TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

***INTAKE EQUIVALENTS** *(Serving levels cc)*

MEDICINE GLASS (1 oz.)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	120	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	CHINA PITCHER	480

DATE 18 MAY 1973

FROM 2400 HOURS TO 2400 HOURS

TOTAL NUMBER HOURS COVERED 0600 - 0600

INTAKE*			OUTPUT		
HOUR	BY MOUTH *State type of fluid & if by tube add (T)*	AMOUNT (cc)	HOUR	URINE *If by catheter add (C)*	AMOUNT (cc)
0630	WATER	120	0720	AMBER	120
0715	GINGER ALE	60	1130	AMBER	240
0910	APPLE JUICE	120	1445	AMBER	180
1200	CLEAR BROTH	180	1800	AMBER	60
1405	GINGER ALE	180	2100	AMBER	360
1645	WATER	120	0545	AMBER (C)	720
1800	CLEAR BROTH	120			
2045	APPLE JUICE	90			
2200	TEA	60			
0300	WATER	120			
				DRAINAGE	
				EMESIS	
			0500	LIGHT YELLOW ē SHREDS OF MUCUS	240
	INTRAVENOUS, SUBCUTANEOUS, CLYSIS *(Specify)*			STOOLS *(Character, color)*	
0600	5% D/W (400 cc.)	400	1230	WATERY BROWN	400
1000	5% D/S ē BEROCCA C (1000cc)	1000	2130	WATERY BROWN	360
1800	5% RINGER'S LACTATE (1000cc)	1000			
0200	5% D/W ē KCL 20 meq (1000cc)	600			
	GRAND TOTAL INTAKE (cc)	4,170		**GRAND TOTAL OUTPUT (cc)**	2,680

USE ADDRESSOGRAPH PLATE

INSTRUCTIONS

Space to left is for mechanical imprinting, if used. If typed or handwritten, enter the following:

PATIENT'S LAST NAME, FIRST NAME, MIDDLE NAME;
REGISTER NUMBER; WARD NUMBER;
NAME OF HOSPITAL OR OTHER MEDICAL FACILITY.

DD FORM 1 SEP 54 **792** 0102 007 9200 ★U.S. GOVERNMENT PRINTING OFFICE: 1971—483-984/35 GPO 938983

VISIBLE FILE SYSTEM AND RELATED NURSING ADMINISTRATIVE RECORD AND AIDS

VISIBLE FILE

PURPOSE

To provide immediate information concerning patient's care, condition and location on ward.

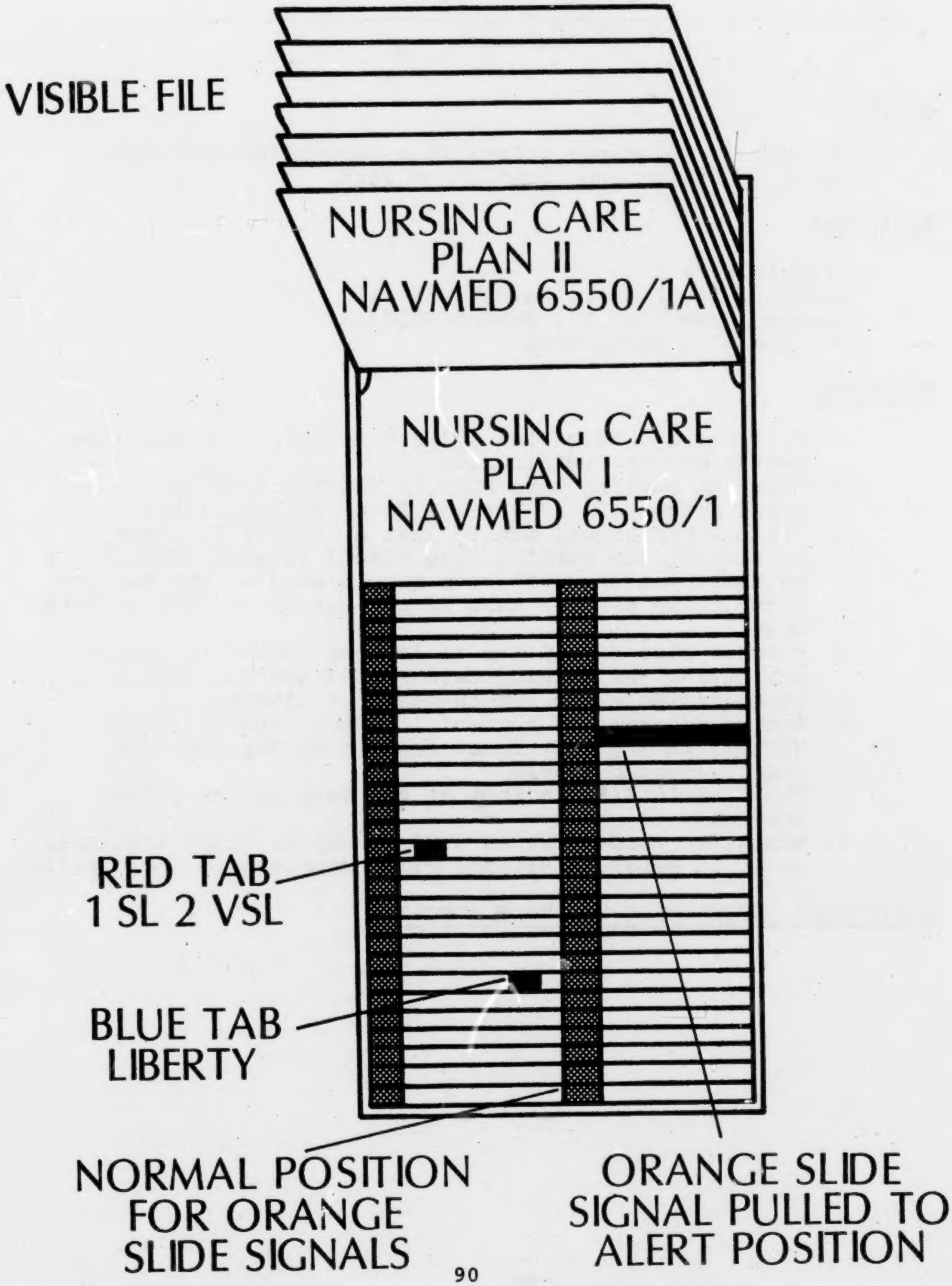
EQUIPMENT

Visible File
Nursing Care Plan I, NavMed 6550/1
Nursing Care Plan II, NavMed 6550/1A
Red and Blue Index tabs

PROCEDURE

1. File Nursing Care Plan I (NavMed 6550/1) in the lower pocket of the Visible File.
2. File the Nursing Care Plan II (NavMed 6550/1A) in the upper pocket of the Visible File (if applicable).
3. Place a red signal tab to left of center in pocket overlaying the Nursing Care Plan I (NavMed 6550/1) on those patients who have been placed on the Serious List. Place two red tabs if patient is on Very Serious List.
4. Place a blue signal tab to left of center in pocket overlaying the Nursing Care Plan I (NavMed 6550/1) on those patients who are on leave or liberty.
5. Record location of patient in space labelled "Bed Number" on far left lower section of Nursing Care Plan I (NavMed 6550/1).
6. The Visible File is kept at the desk in the Nurses' Station.
7. Admission Forms (NavMed 6300/5) may be filed alphabetically in separate Visible File according to local policy.

ADDITIONAL INFORMATION FOR THIS ACTIVITY


VISIBLE FILE
NURSING CARE PLAN II NAVMED 6550/1A
NURSING CARE PLAN I NAVMED 6550/1
RED TAB 1 SL 2 VSL
BLUE TAB LIBERTY
NORMAL POSITION FOR ORANGE SLIDE SIGNALS
ORANGE SLIDE SIGNAL PULLED TO ALERT POSITION

INSTRUCTIONS FOR NURSING ASSESSMENT

PURPOSE

To serve as a guide for obtaining the data necessary for planning the patient's care.

EQUIPMENT

Nursing Assessment, NavMed 6550/11
Nursing Care Plan I, NavMed 6550/1
Nursing Care Plan II, NavMed 6550/1A
Patient's Clinical Record
Inpatient Admission/Disposition Record, NavMed 6300/5
Clip Board
Pen

PROCEDURE

1. Complete as many questions as possible from the patient's Admission Form (NavMed 6300/5) and Clinical Record. Use addressograph plate on bottom left of page 3.
2. Place Nursing Assessment (NavMed 6550/11) on clip board.
3. Interview process:
   a. Explain to the patient that the purpose of this interview is to help both of you to become better acquainted and to plan his care.
   b. Create a quiet and friendly atmosphere.
   c. Record information after sufficient dialogue.
      (1) Use quotations to express patient's feelings when indicated.
      (2) Use short, pertinent phrases when recording patient's responses.
   d. Record observations and nursing evaluation away from patient's unit.
4. Develop Nursing Care Plan I (NavMed 6550/1) and Nursing Care Plan II (NavMed 6550/1A), if applicable.
5. Place Nursing Assessment (NavMed 6550/11) in chart as directed by hospital policy.
6. Record on Nursing Care Plan I (NavMed 6550/1) that assessment was completed, date, and initial. Also record date and time of assessment on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Tell patient that the purpose of the interview is to help the nursing staff plan his care.
2. The Nursing Assessment is only a guide for obtaining information. A patient's response may indicate other questions which should be asked.
3. Attention must be given to timing, privacy, and a sense of caring.

NURSING ASSESSMENT (Continued)

POINTS TO EMPHASIZE (Continued)

4. Only complete and meaningful information will result in a realistic and beneficial Care Plan.
5. Inaccurate information can create more problems than no communication at all.
6. If the patient is unable to provide information, indicate name and relationship of informant.
7. The patient's responses to questions concerning his knowledge of the illness/injury will aid in determining needs and discharge objectives.
8. If patient has medications in his possession, they must be secured according to local policy. If the physician allows patient to continue using her own medication, such as birth control pills, a written order is required.
9. Allergies are not restricted to drugs. The purpose of documenting all allergies is to alert other services providing patient care, such as Food Service, Operating Room, and Radiology departments.
10. Knowledge of patient's reactions to past hospitalization experiences will aid in planning care that will promote comfort and prevent psychological trauma.
11. When discussing valuables with patient, follow local hospital policy in providing for their safe disposition.
12. The patient's activities of daily living, such as eating habits and sleeping patterns, will help identify problems he may have in adjusting to his illness.
13. When discussing visitors with patient, reinforce local policy governing hours and numbers, if indicated. If patient does not expect visitors, provide for diversional activities in developing Nursing Care Plan, when applicable.
14. The patient may desire someone other than next of kin notified in an emergency; however, this does not change official information used by Patient Affairs.
15. Allow patient to ask questions before terminating interview. List those inquiries that indicate needs or problems requiring nursing actions.
16. Evaluation of patient upon completion of Nursing Assessment will help the nurse determine whether the modified Care Plan I is sufficient or whether the more individualized Care Plan II should be used. Discharge objectives should be formulated and written at this time.

SAMPLE

NAVMED 6550/11 (5-73)

NURSING ASSESSMENT

(Please explain to the patient that the purpose of this interview is to help both of you to become better acquainted and to help the nursing staff assist his doctor in providing the best treatment possible.)

PATIENT'S NAME JAMES E. DICKENS GRADE/RATE/STATUS LT/CEC/USN AGE 26

DATE OF ADMISSION 4/23/73 DIAGNOSIS LEFT INGUINAL HERNIA

MODE OF ADMISSION: AMBULATORY ✓ WHEELCHAIR ______ GURNEY ______

ASSESSMENT INFORMANT NAME ______
(If other than patient)
RELATIONSHIP ______

ASSESSMENT OBTAINED BY N. H. Garber LTJG NC USN DATE 4/23/73

1. How long has patient been ill or injured? About 3 months

What does patient know about his illness? Feels limited in meeting physical responsiblities of job. Appears to understand need for surgical procedure

2. Is patient taking any medications now? If yes, what? ______

Any medications with him? Yes ______ No ✓

If yes, what? ______

Disposition ______

3. Is patient allergic to anything (drugs, foods, pollens, etc.)? Yes If yes, what? Adhesive tape

4. Has patient been in a hospital before? Yes ______ No ✓ If yes, what nursing activities were

Helpful ______

Bothered him ______

5. The patient is: Right handed ✓ Left handed ______

6. What does patient plan to do with valuables? Wishes to have his wallet, watch, and ring secured

SAMPLE

NAVMED 6550/11 (5-73)

NURSING ASSESSMENT

7. Does the patient have: (Circle those with him)

____ Cane, crutches
____ Dentures
____ Glasses
____ Hearing Aid
✓ [✓ Contact Lenses]
____ Wig

____ splint, type ____
____ Prothesis, type ____
____ Other, specify ____

8. HABITS OF DAILY LIVING:

What are patient's eating habits? 3 full meals a day

Food dislikes None

Fluid preferences or dislikes None

Any dietary restrictions? No

Sleep habits: Bedtime 2300 Hours of sleep 6-7 hours Up at night No

Why ____ How often ____

Number of pillows 2

Bathing preference: Tub ____ Shower ✓

Defecation: Frequency Daily Time of day A.M.

Irregularities None

Laxative No What kind ____

Urinary: Explain any irregularities None

Does patient need assistance in his habits of daily living: No Explain:

9. Does patient have any special interests, hobbies, or pastimes? Coin collection, sailing

10. Does patient have:

		Where
____	Lacerations, abrasions	
____	Open wounds, new incisions	
____	Bruises	
____	Bed sores	
✓	Skin rash/blisters	BLISTER, LEFT HAND, HEALING WELL
____	Dry skin	
____	Other	

SAMPLE

NAVMED 6550/11 (5-73)

NURSING ASSESSMENT

11. Will patient be expecting visitors? Wife

12. Who would patient like notified in an emergency, if other than next of kin?

NAME ______ Telephone No. ______

ADDRESS ______

13. Education and work:

What has patient's schooling been? Master's degree

What is his job? Civil engineer

14. Questions patient asked? "What time am I scheduled for surgery tomorrow?"

NURSING OBSERVATIONS

Did patient comprehend during interview? Yes If no, explain ______

Does patient have a: If so, describe

No Speech impediment ______

No Hearing difficulty ______

No Language barrier ______

Yes Vision problem Wears contact lenses

No Motor function impairment ______

ADDITIONAL OBSERVATIONS OR REMARKS

NURSING CARE PLAN I, NAVMED 6550/1

PURPOSE

To provide a concise, current record of the physical and therapeutic profile of the patient.

EQUIPMENT

Visible File
Nursing Assessment, NavMed 6550/11
Clinical Record
Nursing Care Plan I, NavMed 6550/1
Stat/Daily Orders, NavMed 6550/10
Addressograph card/plate
Pen and Pencil

PROCEDURE

1. Stamp addressograph card/plate in lower left hand corner of Nursing Care Plan I (NavMed 6550/1). Print name, grade/rank at the bottom edge.
2. Place bed number to which patient is assigned in far left hand corner.
3. Complete the following spaces:
   a. Age
   b. Height
   c. Weight
   d. Religion
   e. Diagnosis
   f. Valuables
   g. Patient class number
   h. Physical traits
   i. Any additional information known at this time.
4. Fill in activity, hygiene, diet, and fluids with the appropriate check marks.
5. Transcribe all medications and treatments including method of administration, time to be given, dosage, date ordered, and date to be renewed. (Treatments and medications that are ordered stat should be recorded on the Stat/Daily Order (NavMed 6550/10) and not entered on the Care Plan.
6. Enter all laboratory and diagnostic tests, examinations and/or consultations. The appropriate requisitions for these tests are completed and sent to the designated office or department.
7. In space marked Comments, enter any and all special instructions for personnel caring for the patient that should be emphasized, such as "Isolation Technique".
8. Determine patient's condition and indicate nursing requirement category: maximum, moderate, or minimum.

NURSING CARE PLAN I, NAVMED 6550/1 (Continued)

PROCEDURE (Continued)

9. Maintain Nursing Care Plan I (NavMed 6550/1) with current information, adding new items as needed and removing those no longer in effect. Delete discontinued medication and treatment orders on the Nursing Care Plan I by blocking them out with a red lead pencil.
10. Medication and Treatment Cards (NavMed 6550/4 and 6550/5) are made out when a medication or treatment is ordered; they must correspond to the entry made on the Nursing Care Plan I (NavMed 6550/1). All medication and treatment cards are reviewed daily with the Nursing Care Plan I (NavMed 6550/1) and with the Doctor's Orders and MAR according to hospital policy.
11. Place Nursing Care Plan I (NavMed 6550/1) in lower section of Visible File.

POINTS TO EMPHASIZE

1. The Nursing Care Plan is a guide; the Nursing Notes is a report.
2. Entries that change frequently such as diet, activity of patient, and renewal dates of medications should be entered in pencil.
3. Stat and "one time only" orders are not transcribed on the Nursing Care Plan I (NavMed 6550/1) but should be carried out immediately.
4. The Stat/Daily Order (NavMed 6550/10) is a worksheet and is discarded when content is no longer valid.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SAMPLE TWO OF NURSING CARE PLAN I (NAVMED 6550/1)

To be filled out on each patient that is admitted.

To be filled in lower part of Visible File.

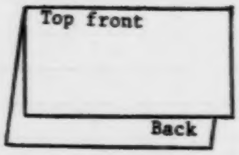
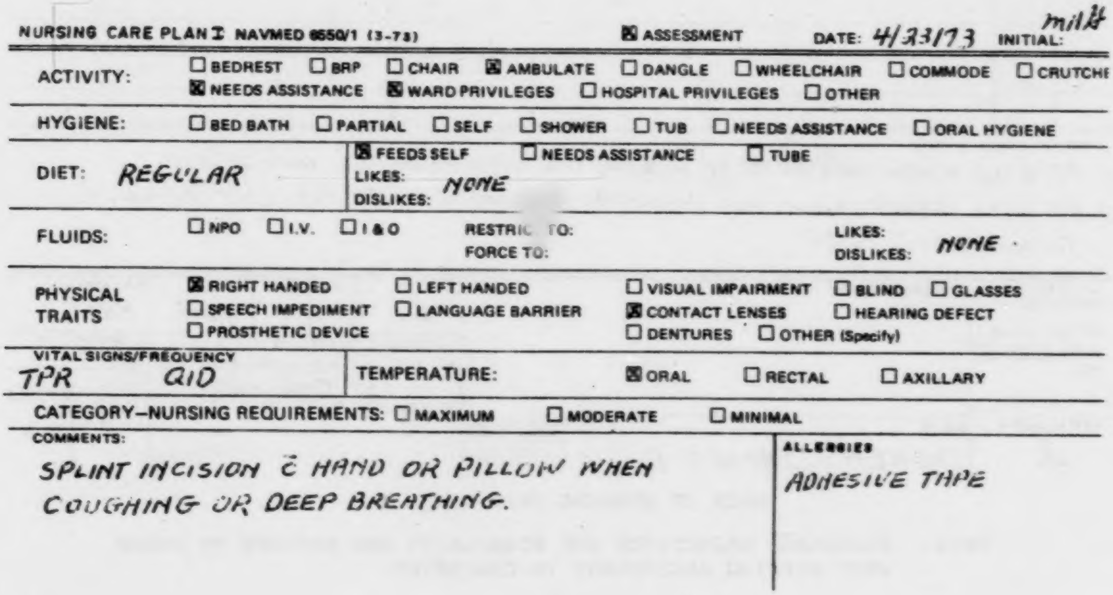


Diagram of NAVMED 6550/1

FRONT OF NURSING CARE PLAN I FOR JAMES D. DICKENS.

APPROXIMATE HOSPITALIZATION 10 DAYS. UNCOMPLICATED SURGERY.

NURSING CARE PLAN I ADEQUATE.



NURSING CARE PLAN I NAVMED 6550/1 (3-73) ☒ ASSESSMENT DATE: 4/23/73 INITIAL: milH

ACTIVITY: ☐ BEDREST ☐ BRP ☐ CHAIR ☒ AMBULATE ☐ DANGLE ☐ WHEELCHAIR ☐ COMMODE ☐ CRUTCHE
☒ NEEDS ASSISTANCE ☒ WARD PRIVILEGES ☐ HOSPITAL PRIVILEGES ☐ OTHER

HYGIENE: ☐ BED BATH ☐ PARTIAL ☐ SELF ☐ SHOWER ☐ TUB ☐ NEEDS ASSISTANCE ☐ ORAL HYGIENE

DIET: REGULAR

☒ FEEDS SELF ☐ NEEDS ASSISTANCE ☐ TUBE

LIKES:

DISLIKES: NONE

FLUIDS: ☐ NPO ☐ I.V. ☐ I & O

RESTRIC[illegible] TO:

FORCE TO:

LIKES:

DISLIKES: NONE

PHYSICAL TRAITS: ☒ RIGHT HANDED ☐ LEFT HANDED ☐ VISUAL IMPAIRMENT ☐ BLIND ☐ GLASSES
☐ SPEECH IMPEDIMENT ☐ LANGUAGE BARRIER ☒ CONTACT LENSES ☐ HEARING DEFECT
☐ PROSTHETIC DEVICE ☐ DENTURES ☐ OTHER (Specify)

VITAL SIGNS/FREQUENCY

TPR QID

TEMPERATURE: ☒ ORAL ☐ RECTAL ☐ AXILLARY

CATEGORY–NURSING REQUIREMENTS: ☐ MAXIMUM ☐ MODERATE ☐ MINIMAL

COMMENTS:

SPLINT INCISION C̄ HAND OR PILLOW WHEN COUGHING OR DEEP BREATHING.

ALLERGIES

ADHESIVE TAPE

NAVMED 6550/1 **BACK** SAMPLE

DATE START 1973	DATE RE-NEW	MEDICATIONS - TREATMENTS	TIME (hours to be given)	DATE OF ORDER/ 1973	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE COM-PLETED
4/24.		DEEP BREATHE AND COUGH.	8-12-4-8-12-4	4/23	CBC, R+M, VDRL	4/23
4/24		AMBULATE	9-1-5-9	4/23	CHEST X-RAY	4/23

DISCHARGE OBJECTIVE(S)

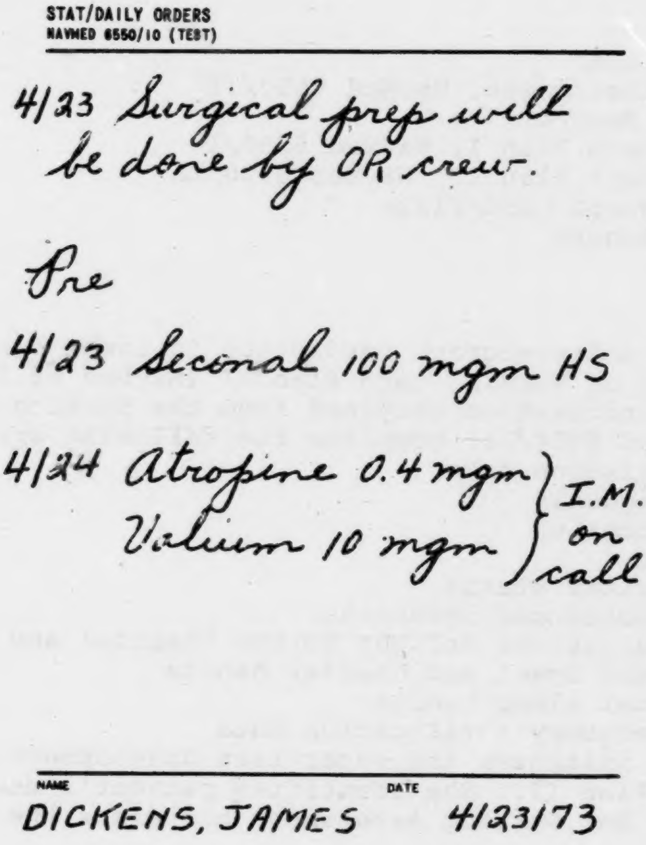
1. PT. WILL KNOW HOW TO KEEP OPERATIVE SITE FREE OF INFECTION
2. PT. WILL UNDERSTAND HIS PHYSICAL LIMITATIONS TO PREVENT DAMAGE TO REPAIRED SITE.

VALUABLES DEPOSITED ☒ YES ☐ NO	ADDRESSOGRAPH	AGE 26	HEIGHT 6'	WEIGHT 204	RELIGION PROT.
PATIENT CLASS NO.		DATE/TIME - OP/DELIVERY 4/24 HERNIOPLASTY LT. INGUINAL			SACRAMENT OF THE SICK TIME ____ DATE ____
BED NUMBER 2	NAME DICKENS, JAMES D.	GRADE RATE LEC LT/USN	DIAGNOSIS		DATE/TIME SL | VSL

BACK OF NURSING CARE PLAN I

NOTE: DISCHARGE OBJECTIVES ARE FORMULATED AND WRITTEN BY NURSE WHEN NURSING ASSESSMENT IS COMPLETED.

SAMPLE



STAT/DAILY ORDERS
NAVMED 6550/10 (TEST)

4/23 Surgical prep will be done by OR crew.

Pre

4/23 Seconal 100 mgm HS

4/24 Atropine 0.4 mgm } I.M.
Valium 10 mgm } on call

NAME DICKENS, JAMES

DATE 4/23/73

NOTE: NAVMED 6550/10 IS DESTROYED AFTER INFORMATION IS CHARTED OR NO LONGER VALID.

NURSING CARE PLAN II, NAVMED 6550/1A

PURPOSE

To plan individual nursing care.
To communicate pertinent information.
To evaluate nursing care.

EQUIPMENT

Visible File
Nursing Assessment, NavMed 6550/11
Clinical Record
Nursing Care Plan I, NavMed 6550/1
Nursing Care Plan II, NavMed 6550/1A
Addressograph Card/Plate
Pen and Pencil

PROCEDURE

1. Stamp addressograph card/plate in lower left hand corner of Nursing Care Plan II (NavMed 6550/1A).
2. With information obtained from the Nursing Assessment (NavMed 6550/11) complete the following spaces:
   a. Admission date
   b. Diagnosis
   c. Education
   d. Job
   e. Marital status
   f. Hobbies and interests
   g. Medications brought to the hospital and disposition
   h. Usual bowel and bladder habits
   i. Usual sleep habits
   j. Emergency notification data
3. Nurse initiates and supervises development of Nursing Care Plan II. She identifies patient's needs/problems after her Nursing Assessment and plans the nursing actions.
4. Discharge objectives in terms of patient response are determined by the nurse and entered as identified during course of patient's hospitalization.
5. Record nursing referrals and date as they are initiated, i.e. Red Cross, Chaplain, Osteotomy Club etc.
6. Place Nursing Care Plan II (NavMed 6550/1A) in upper section of the Visible File.

POINTS TO EMPHASIZE

1. Although the Nursing Care Plan II (NavMed 6550/1A) is initiated by the professional nurse, it is a team effort involving all staff members.

POINTS TO EMPHASIZE (Continued)

2. The Nursing Care Plan II (NavMed 6550/1A) should be realistic and tailored to the individual needs of a patient.
3. Re-evaluate the patient at frequent intervals and update the Nursing Care Plan II (NavMed 6550/1A) as necessary.
4. A need or problem is a difficulty or concern with which the patient is not coping adequately.
5. A nursing action is a specific activity designed to solve patient needs and problems.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SAMPLE

NAVMED 6550/11 (5-73)

NURSING ASSESSMENT

(Please explain to the patient that the purpose of this interview is to help both of you to become better acquainted and to help the nursing staff assist his doctor in providing the best treatment possible.)

PATIENT'S NAME SAMUEL CLEARY GRADE/RATE/STATUS HM3/[illegible] AGE 27

DATE OF ADMISSION 3/20/73 DIAGNOSIS ACUTE MYOCARDIAL INFARCTION

MODE OF ADMISSION: AMBULATORY ____ WHEELCHAIR ____ GURNEY ✓

ASSESSMENT INFORMANT (If other than patient) NAME ____

RELATIONSHIP ____

ASSESSMENT OBTAINED BY S. Muldoon LTJG, NC, USNR DATE 3/21/73

1. How long has patient been ill or injured? Experienced "terrible chest pain last night. Got sick to my stomach and couldn't breathe".

What does patient know about his illness? As a hospital corpsman understands nature of his illness. His father had "heart trouble." Expressed fear of dying.

2. Is patient taking any medications now? If yes, what? ASA occasionally

Any medications with him? Yes ____ No ✓

If yes, what? ____

Disposition ____

3. Is patient allergic to anything (drugs, foods, pollens, etc.)? Yes If yes, what? Compazine, thorazine, seafoods, and iodine

4. Has patient been in a hospital before? Yes ✓ No ____ If yes, what nursing activities were

Helpful ____

Bothered him Resented being awakened early for nursing measures.

5. The patient is: Right handed ✓ Left handed ____

6. What does patient plan to do with valuables? Valuables taken home by wife.

SAMPLE

NAVMED 6550/11 (5-73)

NURSING ASSESSMENT

7. Does the patient have: (Circle those with him)

______ Cane, crutches
______ Dentures
__✓__ [✓ Glasses]
______ Hearing Aid
______ Contact Lenses
______ Wig
______ splint, type ______
______ Prothesis, type ______
______ Other, specify ______

8. HABITS OF DAILY LIVING:

What are patient's eating habits? 3 large meals a day and evening snack.

Food dislikes None

Fluid preferences or dislikes Drinks 8-10 cups of coffee daily

Any dietary restrictions? Seafoods (allergic)

Sleep habits: Bedtime 2300 Hours of sleep 6 hours Up at night No

Why ______ How often ______

Number of pillows None

Bathing preference: Tub ______ Shower ✓

Defecation: Frequency Once daily Time of day A.M.

Irregularities None

Laxative No What kind ______

Urinary: Explain any irregularities None

Does patient need assistance in his habits of daily living: No Explain:

9. Does patient have any special interests, hobbies, or pastimes? Football, photography

10. Does patient have: Where

______ Lacerations, abrasions ______
______ Open wounds, new incisions ______
______ Bruises ______
______ Bed sores ______
__✓__ Skin rash, [✓ blisters] LEFT THUMB
______ Dry skin ______
______ Other ______

SAMPLE

NAVMEL 6550/11 (5-73) **NURSING ASSESSMENT**

11. Will patient be expecting visitors? Wife

12. Who would patient like notified in an emergency, if other than next of kin?

NAME ______ Telephone No. ______

ADDRESS ______

13. Education and work:

What has patient's schooling been? Associate Degree

What is his job? X-ray technician

14. Questions patient asked? Doctor has already answered them

NURSING OBSERVATIONS

Did patient comprehend during interview? Yes If no, explain ______

Does patient have a: If so, describe

No Speech impediment ______

No Hearing difficulty ______

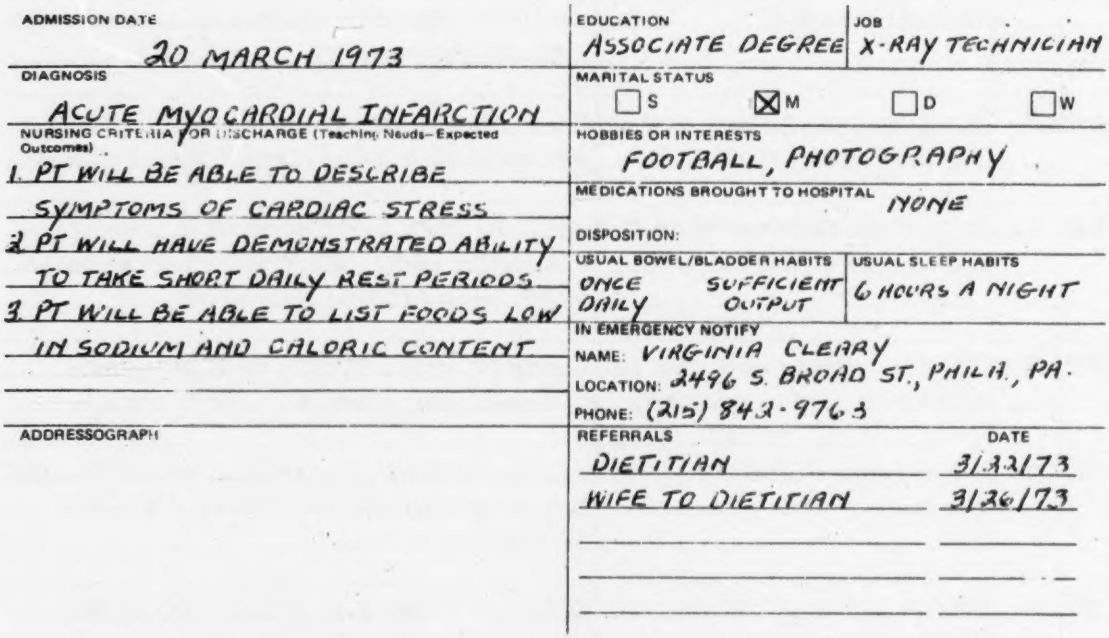
No Language barrier ______

Yes Vision problem Wears glasses

______ Motor function impairment ______

ADDITIONAL OBSERVATIONS OR REMARKS

Appears very apprehensive



ADMISSION DATE
20 MARCH 1973

DIAGNOSIS
ACUTE MYOCARDIAL INFARCTION

NURSING CRITERIA FOR DISCHARGE (Teaching Needs—Expected Outcomes)
1. PT WILL BE ABLE TO DESCRIBE SYMPTOMS OF CARDIAC STRESS
2. PT WILL HAVE DEMONSTRATED ABILITY TO TAKE SHORT DAILY REST PERIODS
3. PT WILL BE ABLE TO LIST FOODS LOW IN SODIUM AND CALORIC CONTENT

ADDRESSOGRAPH

EDUCATION: ASSOCIATE DEGREE
JOB: X-RAY TECHNICIAN

MARITAL STATUS
☐ S ☒ M ☐ D ☐ W

HOBBIES OR INTERESTS
FOOTBALL, PHOTOGRAPHY

MEDICATIONS BROUGHT TO HOSPITAL NONE

DISPOSITION:

USUAL BOWEL/BLADDER HABITS: ONCE DAILY SUFFICIENT OUTPUT
USUAL SLEEP HABITS: 6 HOURS A NIGHT

IN EMERGENCY NOTIFY
NAME: VIRGINIA CLEARY
LOCATION: 2496 S. BROAD ST., PHILA., PA.
PHONE: (215) 843-9763

REFERRALS	DATE
DIETITIAN	3/22/73
WIFE TO DIETITIAN	3/26/73

SAMPLE OF NURSING CARE PLAN II (NAVMED 6550/1A)

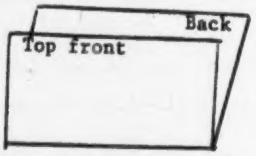


Diagram of NAVMED 6550/1A

To be used when a professional nurse determines that a patient requires more individualized care than can be planned with the modified NAVMED 6550/1.

To be filed in the upper part of the Visible File.

(NURSING CARE PLAN I FILLED OUT FOR PATIENT. SAMPLE NOT INCLUDED.)

FRONT OF NURSING CARE PLAN II FOR SAMUEL CLEARY.

APPROXIMATE HOSPITALIZATION 28 DAYS.

NURSING CARE PLAN I INADEQUATE TO PLAN NURSING CARE REQUIRED FOR THIS PATIENT.

DISCHARGE OBJECTIVES ARE FORMULATED AND WRITTEN BY NURSE WHEN NURSING ASSESSMENT IS COMPLETED.

NURSING CARE PLAN II NAVMED 6550/1A (3-73) SAMPLE

DATE 1973	PROBLEM NUMBER	PATIENT NEEDS/PROBLEMS (State Reason Why)	NURSING ACTIONS (Be Specific)
3/21	1	ANXIETY AND FEAR OF DYING DUE TO INFARCT	SPEND 30 MIN AT BEDSIDE EACH A.M. AND P.M. AND PRN ACTIVELY LISTENING AND RESPONDING TO CONCERNS
3/21	2	SEVERE CHEST PAIN DUE TO VASOCONSTRICTION	GIVE MORPHINE PROMPTLY AND CLOSELY OBSERVE REACTION. CHART TIME INTERVAL.
3/21	3	POTENTIAL THROMBOPHLEBITIS DUE TO IMMOBILIZATION	DURING A.M CARE REMOVE STOCKINGS AND WASH LEGS. DO NOT RUB. DO PASSIVE ROM. APPLY CLEAN STOCKINGS.
3/21	4	POSSIBLE PHLEBITIS DUE TO CONTINUOUS I.V. THERAPY	CLEANSE INJECTION SITE C̄ ALCOHOL SPONGE AND REPLACE TAPE DAILY.
3/23	5	ANGER AND DENIAL DUE TO ILLNESS.	ALLOW PATIENT TO EXPRESS HIS FEELINGS. RESPOND MATTER-OF-FACTLY TO HIS CONCERNS
3/24	6	INABILITY TO RELAX DUE TO BEING PAIN-FREE NOW AND PAST PATTERNS OF MUCH ACTIVITY	DISCUSS C̄ PATIENT THE NEED FOR PERIODS OF TOTAL RELAXATION. REMOVE DISTRACTING MATERIAL, IF NECESSARY.
3/27	7	FRUSTRATION DUE TO ADDITIONAL DIETARY RESTRICTION (1200 CALORIES).	GIVE PATIENT POSITIVE REINFORCEMENT IN KEEPING AND MAINTAINING DIET.

BACK OF NURSING CARE PLAN II

WARD REPORT, NAVMED 6550/2

PURPOSE

To provide up-to-date ward statistics.

EQUIPMENT

Ward Report, NavMed 6550/2
Day Book

PROCEDURE

1. Start Ward Report at 0001:
   - a. Name or number of ward.
   - b. Authorized bed capacity.
   - c. Number of patients remaining from last report.
2. During the 24 hour period, (from 0001 to 2400), all changes occurring on the ward such as Admissions, Discharges, TOW's, AOW's, and deaths must be entered at the time of occurrence.
   - a. List entries as follows, allowing space between each group if possible.
     - (1) A - Admissions
     - (2) AOW - Admissions from other wards
     - (3) TOW - Transferred to other wards
     - (4) D - Discharges
     - (5) DD - Deaths
     - (6) UA - Unauthorized Leave
     - (7) L - Leave
     - (8) SAH - Subsisting at home
   - b. First column - Record the abbreviated patient category, i.e. A, AOW, TOW etc.
   - c. Second column - Name of patient. Record last name, first name and middle initial of patient.
   - d. Third column - Rate. Record patient's rate/rank, branch of service, retired (Ret.), or Civilian Humanitarian (Civ Hum) if applicable.
   - e. Fourth column - Remarks
     - 1. A - Record admission diagnosis.
     - 2. AOW - Record diagnosis and transferring ward.
     - 3. TOW - Record ward transferred to.
     - 4. D - Record destination, to duty or home.
     - 5. DD - Record time patient expired.
     - 6. UA - Record time and date patient left ward without authorized permission.
     - 7. L - Record dates for authorized leave.

WARD REPORT NAVMED, 6550/2

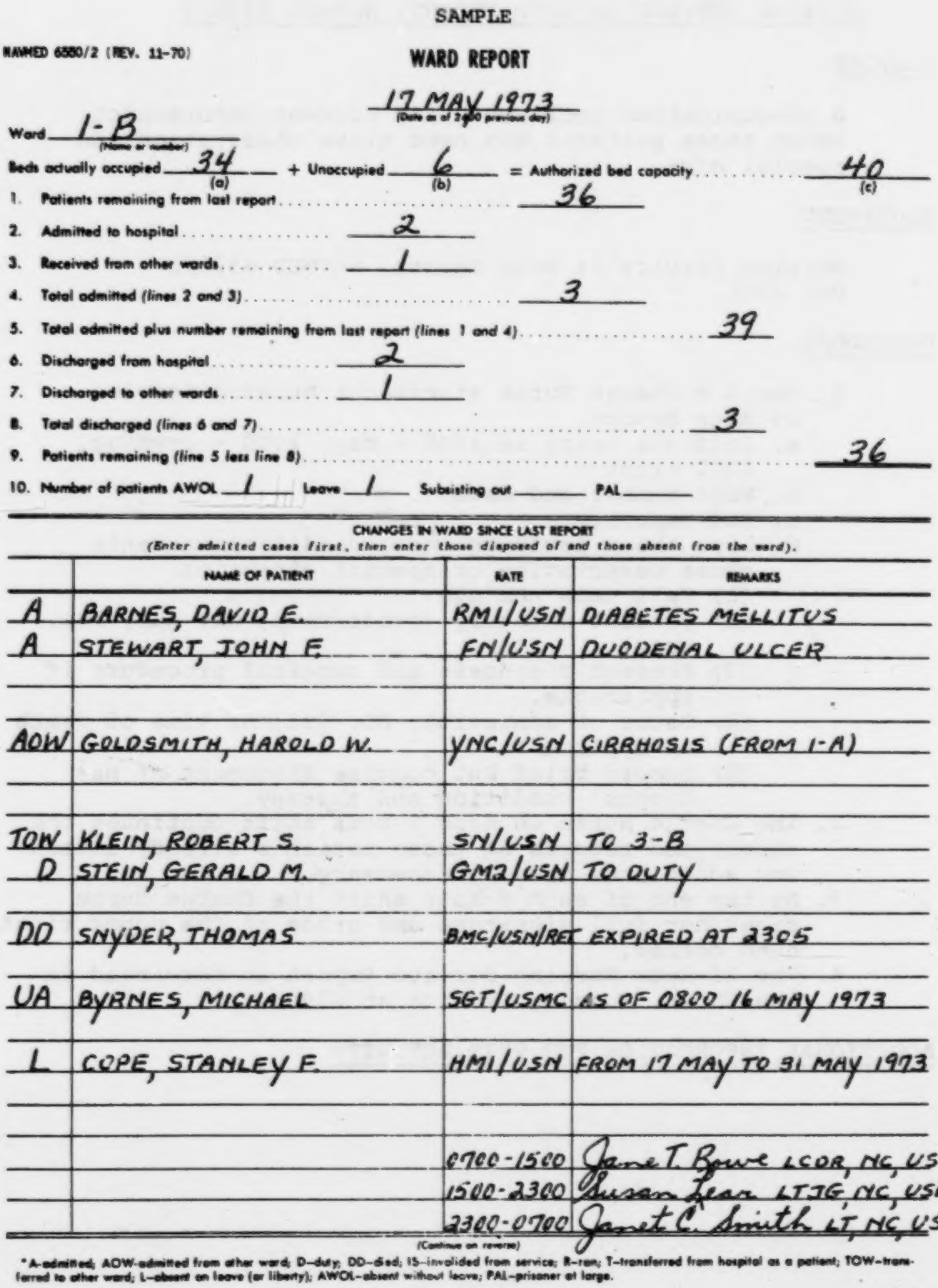
PROCEDURE (Continued)

3. At the end of each 8 hour period the Charge Nurse signs her full signature and rank at the bottom right hand corner.
4. At the end of the 24 hour period (2400) all changes (numbers 2 through 10) are totaled and a summary entered in the blanks at the head of the report - Beds actually occupied, unoccupied.
5. The Ward Report (NavMed 6550/2) is kept in the Day Book at the Nurses' Station. At 2400 it is completed and sent to a Patient Affairs representative or as directed by local hospital policy.

POINTS TO EMPHASIZE

1. The Ward Report must be accurate and current so that a true accounting of the ward and hospital census can be determined at any time during the 24 hour period.

ADDITIONAL INFORMATION FOR THIS ACTIVITY



SAMPLE

NAVMED 6550/2 (REV. 11-70)

WARD REPORT

17 MAY 1973
(Date as of 2400 previous day)

Ward 1-B
(Name or number)

Beds actually occupied 34 (a) + Unoccupied 6 (b) = Authorized bed capacity 40 (c)

1. Patients remaining from last report 36
2. Admitted to hospital 2
3. Received from other wards 1
4. Total admitted (lines 2 and 3) 3
5. Total admitted plus number remaining from last report (lines 1 and 4) 39
6. Discharged from hospital 2
7. Discharged to other wards 1
8. Total discharged (lines 6 and 7) 3
9. Patients remaining (line 5 less line 8) 36
10. Number of patients AWOL 1 Leave 1 Subsisting out ____ PAL ____

CHANGES IN WARD SINCE LAST REPORT
(Enter admitted cases first, then enter those disposed of and those absent from the ward).

	NAME OF PATIENT	RATE	REMARKS
A	BARNES, DAVID E.	RM1/USN	DIABETES MELLITUS
A	STEWART, JOHN F.	FN/USN	DUODENAL ULCER
AOW	GOLDSMITH, HAROLD W.	YNC/USN	CIRRHOSIS (FROM 1-A)
TOW	KLEIN, ROBERT S.	SN/USN	TO 3-B
D	STEIN, GERALD M.	GM2/USN	TO DUTY
DD	SNYDER, THOMAS	BMC/USN/RET	EXPIRED AT 2305
UA	BYRNES, MICHAEL	SGT/USMC	AS OF 0800 16 MAY 1973
L	COPE, STANLEY F.	HM1/USN	FROM 17 MAY TO 31 MAY 1973
		0700-1500	Jane T. Bowe LCDR, NC, USN
		1500-2300	Susan Lear LTJG, NC, USNR
		2300-0700	Janet C. Smith LT, NC, USN

(Continue on reverse)

*A-admitted; AOW-admitted from other ward; D-duty; DD-died; IS-invalided from service; R-ran; T-transferred from hospital as a patient; TOW-transferred to other ward; L-absent on leave (or liberty); AWOL-absent without leave; PAL-prisoner at large.

NURSING SERVICE 24-HOUR REPORT, NAVMED 6550/3

PURPOSE

A communication tool conveying current information about those patients who need close observation and special care.

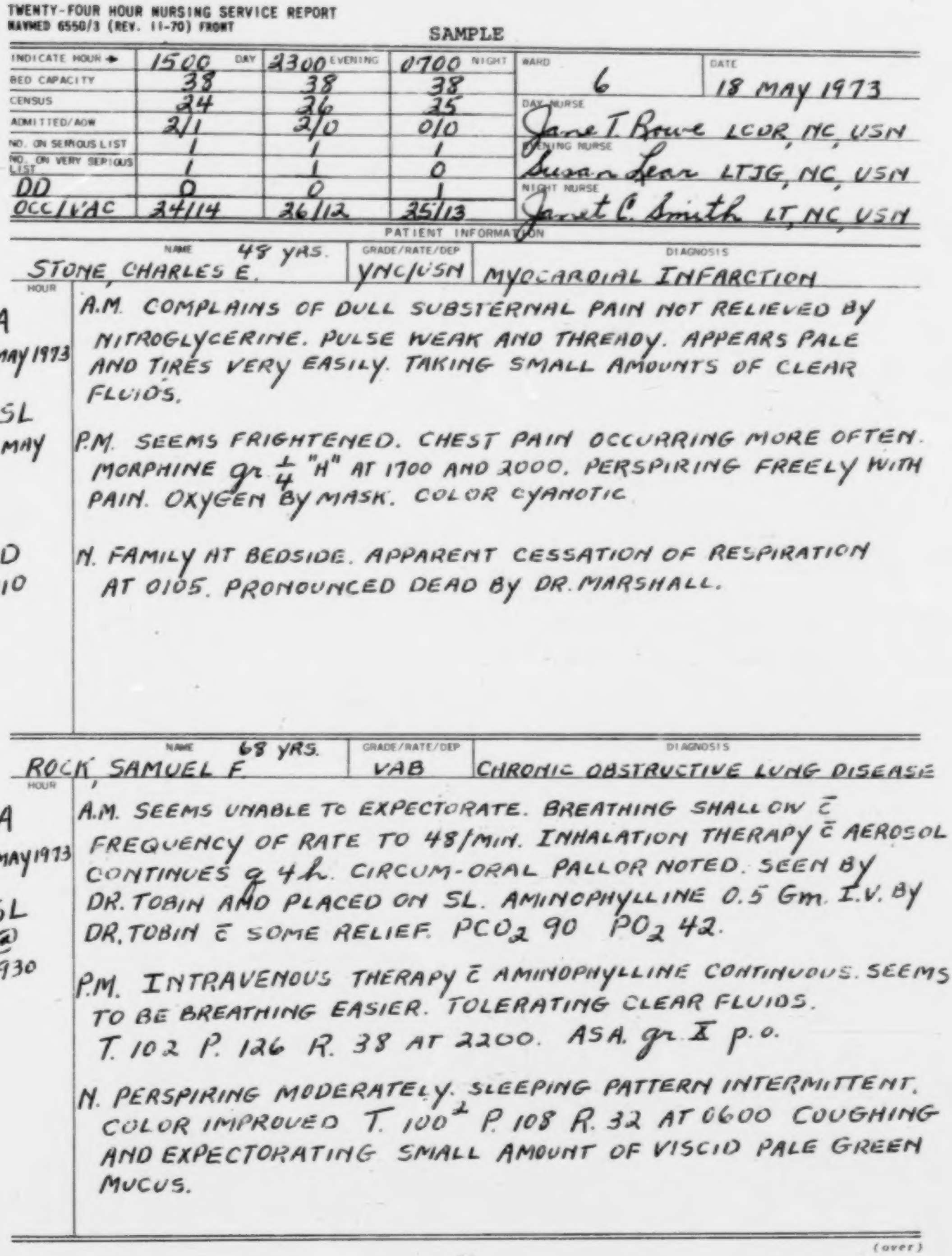
EQUIPMENT

Nursing Service 24 Hour Report, NAVMED 6550/3
Day Book

PROCEDURE

1. The A M Charge Nurse starts the Nursing Service 24-Hour Report.
   a. Indicate hours as 1500 - day, 2300 - evening, 0700 night
   b. Ward number and date
   c. Bed capacity
   d. List those patients whose condition warrants close observation or special attention
      (1) Full name and age
      (2) Patient category (grade/rate, Civ Hum, Dep. etc.)
      (3) Present diagnosis and surgical procedure if applicable.
      (4) Dates of admission, SL, VSL, or time of death if applicable
      (5) Record brief but concise statement of patients' condition and therapy.
2. The Charge Nurse on each 8 hour shift continues the report and records on those patients already listed and additional ones as necessary.
3. At the end of each 8-hour shift the Charge Nurse signs her full signature and grade at the upper right hand corner.
4. The 24-Hour Nursing Service Report is forwarded to the Chief, Nursing Service at 0700.

ADDITIONAL INFORMATION FOR THIS ACTIVITY



TWENTY-FOUR HOUR NURSING SERVICE REPORT
NAVMED 6550/3 (REV. 11-70) FRONT

SAMPLE

INDICATE HOUR →	1500 DAY	2300 EVENING	0700 NIGHT	WARD 6	DATE 18 MAY 1973
BED CAPACITY	38	38	38	DAY NURSE Jane T. Rowe LCDR, NC, USN	
CENSUS	24	26	35		
ADMITTED/AOW	2/1	2/0	0/0		
NO. ON SERIOUS LIST	1	1	1	EVENING NURSE Susan Lear LTJG, NC, USN	
NO. ON VERY SERIOUS LIST	1	1	0		
DD	0	0	1	NIGHT NURSE Janet C. Smith LT, NC, USN	
OCC/VAC	24/14	26/12	35/13		

PATIENT INFORMATION

NAME	GRADE/RATE/DEP	DIAGNOSIS
STONE, CHARLES E. 48 YRS.	YNC/USN	MYOCARDIAL INFARCTION

HOUR	
A 16 MAY 1973	A.M. COMPLAINS OF DULL SUBSTERNAL PAIN NOT RELIEVED BY NITROGLYCERINE. PULSE WEAK AND THREADY. APPEARS PALE AND TIRES VERY EASILY. TAKING SMALL AMOUNTS OF CLEAR FLUIDS.
VSL 16 MAY	P.M. SEEMS FRIGHTENED. CHEST PAIN OCCURRING MORE OFTEN. MORPHINE gr $\frac{1}{4}$ "H" AT 1700 AND 2000. PERSPIRING FREELY WITH PAIN. OXYGEN BY MASK. COLOR CYANOTIC
DD 0110	N. FAMILY AT BEDSIDE. APPARENT CESSATION OF RESPIRATION AT 0105. PRONOUNCED DEAD BY DR. MARSHALL.

NAME	GRADE/RATE/DEP	DIAGNOSIS
ROCK, SAMUEL F. 68 YRS.	VAB	CHRONIC OBSTRUCTIVE LUNG DISEASE

HOUR	
A 10 MAY 1973 SL @ 0930	A.M. SEEMS UNABLE TO EXPECTORATE. BREATHING SHALLOW c̄ FREQUENCY OF RATE TO 48/MIN. INHALATION THERAPY c̄ AEROSOL CONTINUES q 4h. CIRCUM-ORAL PALLOR NOTED. SEEN BY DR. TOBIN AND PLACED ON SL. AMINOPHYLLINE 0.5 Gm. I.V. BY DR. TOBIN c̄ SOME RELIEF. PCO_2 90 PO_2 42.
	P.M. INTRAVENOUS THERAPY c̄ AMINOPHYLLINE CONTINUOUS. SEEMS TO BE BREATHING EASIER. TOLERATING CLEAR FLUIDS. T. 102 P. 126 R. 38 AT 2200. ASA. gr I p.o.
	N. PERSPIRING MODERATELY. SLEEPING PATTERN INTERMITTENT. COLOR IMPROVED T. 100^2 P. 108 R. 32 AT 0600 COUGHING AND EXPECTORATING SMALL AMOUNT OF VISCID PALE GREEN MUCUS.

(over)

II

ADMISSION AND DISCHARGE OF PATIENTS

ADMISSION OF PATIENT

PURPOSE

To provide medical, dental, and nursing care in an enviroment where facilities for this care are concentrated.

EQUIPMENT

Clinical Records, Standard Form 500 series
Thermometer tray, T.P.R. Book
Sphygmomanometer, stethoscope
Bed tag
Addressograph plate
Visible File Frame
Admission Record, NavMed 6300/5
Nursing Assessment, NavMed 6550/11
Nursing Care Plan I, NavMed 6550/1
Nursing Care Plan II, NavMed 6550/1A
Ward Report, NavMed 1550/2
Diet Sheet, NavMed-18
Linen as needed: pajamas, slippers, towel, washcloth
Identification band

PROCEDURE

1. Greet patient in a courteous manner and introduce self.
2. Seat patient or put to bed if condition so indicates. Give him necessary linen and introduce him to his neighbors.
3. Take temperature, pulse, respiration, blood pressure, height and weight. Ask patient if he has any allergies.
4. If nurse is not on ward, notify immediately.
5. Notify ward medical officer of patient's arrival.
6. Enter patient's name on Ward Report and Diet Sheet. Use addressograph plate to stamp Clinical Records and Nursing Care Plan I and II. Print patient's last name, first name, and middle initial on label for chart holder. Print patient's name, rank/rate, date of admission and religion on bed tag.
7. If condition permits, interview patient and complete Nursing Assessment. This is the professional nurse's responsibility.
8. Begin Nursing Notes by charting:
   a. Date, time, manner of admission, sex and age.
   b. Blood pressure, pulse, respirations, temperature, height and weight.

PROCEDURE (Continued)

8.
   c. Chief complaint and other complaints of patient.
   d. Source of pertinent information, when received from relatives.
   e. Symptoms that the patient shows and your pertinent observations concerning him.
   f. Any known allergies.
   g. Notification of and examination by medical officer.
   h. Medications and nursing measures given. Observations made of the effects of medications and treatments.
9. File Admission Record (NavMed 6300/5) as directed by local policy.
10. Place addressograph plate in holder arranged in alphabetical order.
11. Apply patient's identification band on wrist if this has not been done in the admission room.
12. Transcribe medication and treatment orders and other appropriate information on Nursing Care Plan I (NavMed 6550/1) and file in lower pocket of Visible File.
13. If the professional nurse determines from the Nursing Assessment that a Nursing Care Plan II (NavMed 6550/1A) is necessary, transcribe appropriate information and develop Nursing Actions to meet patient needs or problems.
14. File Nursing Care Plan II (NavMed 6550/1A) in upper pocket of Visible File.

POINTS TO EMPHASIZE

1. If a patient arrives on the ward with Doctor's Orders (SF 508), carry out any orders promptly which may have been written.
2. If condition permits, instruct patient to read Information for Patients and Ward Regulations.
3. Stress importance of depositing valuables and money with Disbursing Officer for safekeeping. After routine working hours, deposit may be made with Officer of the Day.
4. Notify Food Service Department, if patient arrives prior to mealtime.
5. Ambulatory patient may take laboratory and x-ray forms to designated places to have procedure done.
6. Obtain Clinical Records if patient has been admitted previously.
7. Bed tag is to include only name, grade/rate, date of admission, and religion.

SAMPLE

ADMISSION NURSING NOTE

(Samuel Cleary, HM2, USN)

Standard Form 510
Rev. Feb. 1956
Bureau of the Budget
Circular A—32
Stock No. 1-0109-201-2304

CLINICAL RECORD | **NURSING NOTES** *(Sign all notes)*

DATE 1973	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20 MAR		2200	ADMITTED 27 YEAR OLD CAUCASIAN MALE BY GUERNEY
			FROM E.R. c̄ DIAGNOSIS OF ACUTE MYOCARDIAL
			INFARCTION. PLACED ON MONITOR. NORMAL SINUS
			RHYTHM s̄ ECTOPIC BEATS. T-97 P-72 R-20.
			BP 136/98. COLOR RATHER PALE. COMPLAINS OF
			HAVING HAD "TERRIBLE CHEST PAIN." MORPHINE
			GIVEN IN E.R. APPEARS TO BE FAIRLY COMFORTABLE
			AT THIS TIME. ANXIETY REVEALED IN CONVERSATION.
			"I COULDN'T GET MY BREATH AND THOUGHT I WAS
			DYING." DR BENNISH PRESENT. I.V. 5% D/W TO KVO
			STARTED IN E.R. BY DR. BENNISH USING #16 JELCO
			CATHETER. RATE REGULATED AT 15 gtt/MIN.
			KNOWN ALLERGIES: COMPAZINE, THORAZINE,
			SEA FOODS AND IODINE.
		2215	PLACED ON SL BY DR. BENNISH. CHAPLAIN DRIER
			IN TO ADMINISTER SACRAMENT OF THE SICK.
		2230	VALUABLES INVENTORIED AND GIVEN TO WIFE.
		2250	ANTI-EMBOLITIC STOCKINGS APPLIED.
		2300	EXPERIENCING NO CHEST PAIN AT THIS TIME.
			NURSING ASSESSMENT WILL BE COMPLETED IN
			A.M. S. Muldoon, LTJG, NC, USNR

Continue on reverse side

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.

WARD NO. 1-C

USE ADDRESSOGRAPH PLATE

NURSING NOTES
Standard Form 510
510-107

PLATE NO. 10814 (REV.)

ASSISTING WITH A PHYSICAL EXAMINATION

PURPOSE

To aid the doctor in making a diagnosis and planning therapy.
To aid in planning the necessary nursing care.

EQUIPMENT

Tray with:
- Sheet for draping
- Towel
- Flashlight
- Percussion hammer
- Tongue Depressors
- Ophthalmoscope and otoscope
- Sphygmomanometer, stethoscope
- Tape measure
- Paper wipes
- Safety pins
- Skin marking pencil
- Alcohol sponges
- Rubber glove/finger cot or disposable gloves
- Paper bag

PROCEDURE

1. Screen patient and explain procedure to him.
2. Offer bedpan or urinal before examination.
3. Assemble all necessary equipment at bedside.
4. Place patient in a comfortable position.
5. Drape patient with sheet. Fold bedclothes to foot of bed.
6. Head, eyes, ears, mouth and throat are usually examined first.
    a. Hand ophthalmoscope to the medical officer.
    b. Hand flashlight and tongue depressor.
7. Chest:
    a. Assist patient to sitting position if condition permits.
    b. Hand patient paper wipes to hold over mouth while he coughs when asked to do so.

ASSISTING WITH A PHYSICAL EXAMINATION (Continued)

PROCEDURE (Continued)

8. Abdomen:
   Place patient in recumbent position.
9. Extremities:
   a. Drape to expose both extremities.
   b. Hand percussion hammer to medical officer.
10. Upon completion of examination, straighten bedclothes. Make patient comfortable.
11. Charting - include time, examination, by whom, and any observation you have made.

POINTS TO EMPHASIZE

A nurse or female attendant should always be available when a female patient is being examined.

CARE OF EQUIPMENT

Clean and reset equipment tray.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

A.O.W. OF PATIENT

(Admitted from Other Ward)

PURPOSE

To provide necessary care and facilities for treatment.

PROCEDURE

1. Greet and receive patient and accept his records.
2. Explain ward routine and regulations which affect him.
3. Notify Ward Medical Officer and nurse.
4. Record name on the Ward Report as AOW; add name to T.P.R. book and Diet List/Sheet.
5. File Nursing Care Plan I and Nursing Care Plan II, if applicable, Admission Record, Addressograph plate and Medication and Treatment Cards.
6. Record date, time and manner of transfer on Nursing Notes.
7. Assign bed, place bed tag in holder on bed and introduce the patient to ward personnel and other patients.

POINTS TO EMPHASIZE

1. Notify Diet Kitchen of admission on ward.
2. Examine clinical record carefully to determine whether all orders are verified and all medications/treatments are up-to-date.
3. Be familiar with local policy concerning cancellation and rewriting of doctors' orders when patients are A.O.W.'ed.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

T.O.W. OF PATIENT

(Transfer to Other Ward)

PURPOSE

To provide necessary care and facilities for treatment.

PROCEDURE

1. Make notation on the Nursing Notes of the date, hour and ward to which the patient is being transferred.
2. Make out Ward Transfer Slip, if applicable.
3. Enter patient's name as T.O.W. on Ward Report.
4. Remove name from T.P.R. book and Diet List/Sheet.
5. Send patient to ward with his gear, complete chart, Health Record, Nursing Care Plan I and Nursing Care Plan II, if applicable, Admission Record, medicine cards, addressograph plate, and bed tag.

POINTS TO EMPHASIZE

1. Before transferring the patient, notify the ward to which he is being transferred.
2. Avoid transferring patient during meal or visiting hours.
3. Chart should be completed by Ward Medical Officer before transfer is made.
4. If patient is transferred to a convalescent ward, the Ward Medical Officer will retain the Health Record.
5. If the patient is transferred to a convalescent ward, instruct him regarding sick call routine.
6. Notify Diet Kitchen of patient's transfer.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

DISCHARGE OF PATIENT

PURPOSE

To return a patient to duty or home upon completion of his treatment.

EQUIPMENT

Check-out slip (check local hospital instructions)
Equipment and linen for unit

PROCEDURE

1. Close out patient's chart. Arrange in numerical and chronological order. Send to doctor's office.
2. Remove Admission/Disposition Record (NavMed 6300/5) from Visible File.
3. Indicate places on reverse side of admission slip or a local check-out slip from which patient must have clearance.
4. Instruct patient to check out at designated places and return to ward for final initialing of check-out slip.
5. Enter the letter "D" followed by patient's name, grade/rate, disposition on Ward Report.
6. Remove patient's name from all other ward records.
7. Discard bed tag, medication and treatment cards and addressograph plate.
8. Notify Diet Kitchen of patient's discharge, if applicable.
9. Have active duty enlisted patient clean and make up his unit. (Follow local policy.)
10. Discharge notation on Nursing Notes:
    a. When patient is discharged to duty/home and chart is closed out 24 to 48 hours before actual discharge:
        (1) Enter date and time the chart is closed.
        (2) Enter the following statement in the Remarks column: "To be discharged to duty on_________". (Indicate actual date.)
    b. When chart is closed out at same time or after the patient is actually discharged:
        (1) Include date and time of discharge.
11. Send chart to Patient Affairs office after Medical Officer has written or dictated Narrative Summary.

DISCHARGE OF PATIENT (Continued)

POINTS TO EMPHASIZE

1. Dependents and supernumerary patients should be cleared by Collection Agent before being discharged.
2. Patients must be removed by doctor's order from SL or VSL before discharge.
3. Make sure the discharge order has been written by the doctor, all Doctor's Orders have been verified, and the Admission/Disposition Record (NavMed 6300/5) has been completed.
4. The discharge nursing note should reflect whether the discharge objectives in terms of patient response.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SAMPLE

Standard Form 510
Rev. Feb. 1958
Bureau of the Budget
Circular A—32
Stock No. 1-0109-201-2304

DISCHARGE NURSING NOTE

(Samuel Cleary, HM2, USN)

CLINICAL RECORD | **NURSING NOTES** *(Sign all notes)*

DATE 1973	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 MAY	1050		VISITED BY DR. BENNISH AND INSTRUCTED TO RETURN
			TO MEDICAL CLINIC 11 JUNE 1973. WIFE PRESENT.
			INDICATED VERBALLY HER DESIRE TO REINFORCE
			TEACHING REGIME AT HOME. PATIENT CAN VERBALIZE
			SYMPTOMS OF OVER-EXERTION. UNDERSTANDS
			NEED TO HAVE A DAILY AFTERNOON REST PERIOD.
			STATED, "IT WAS HARD LEARNING TO SLOW DOWN.
			NOW I KIND OF LOOK FORWARD TO THAT HOUR
			SNOOZE." PATIENT CAN LIST FOODS LOW IN SODIUM
			AND CALORIES. GIVEN ADDITIONAL LITERATURE
			COVERING METHODS OF COOKING.
	1120		DISCHARGED BY WHEELCHAIR IN PRESENCE OF
			WIFE TO HOME.
			S. Muldoon LTJG, NC, USNR

Continue on reverse side

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
510-107
PLATE NO. 10814 (REV.)

USE ADDRESSOGRAPH PLATE

CARE OF THE DEAD

PURPOSE

To prepare the body for the morgue.
To care for the personal effects of the deceased.

EQUIPMENT

Morgue pack or box which should include:
- Roll of cotton or cellulose
- Two rolls of 3 inch gauze bandage
- Two clean surveyed sheets
- Old muslin for diaper
- Adhesive tape
- Safety pins
- Three manila or body identification tags
- Clean dressings, if needed
- "T" binder
- Screen, if necessary

PROCEDURE

1. If on open ward, screen unit so other patients will not be disturbed.
2. Lower backrest. Straighten body. Leave one pillow under head.
3. Close eyes. Replace dentures and all prostheses.
4. Change dressings. Remove drainage tubes. Close draining wounds with adhesive tape.
5. Bathe body. Take care of identification band according to local policy.
6. Place pad of cotton or cellulose over pubic region and rectum. Secure in place with diaper or T-binder.
7. Make out identification tags containing the following information: Name, serial number, grade/rate, dianosis, ward, date and time of death, and the Medical Officer's name who pronounced him dead.
   a. Tie one tag to great toe (ankle on infant).
   b. Tie one tag to right arm just below elbow.
8. Place arms over chest. Pad wrists with cotton or cellulose and, using 3" roller gauze bandage, loosely bandage wrists together to prevent bruising or injury of arms or hands.
9. Place clean sheet diagnonally under body. Fold upper corners over head, lower corner over feet, bring sides over to completely cover body. Secure with safety pins.

CARE OF THE DEAD (Continued)

PROCEDURE (Continued)

10. Pin third identification tag to outside of sheet.
11. Place body on stretcher. Cover with second sheet.
12. Notify morgue watch.
13. Transfer body to morgue with as little disturbance to other ward patients as possible.
14. Inventory and itemize patient's personal effects.
    a. Commissioned officer patient - two commissioned officers.
    b. Enlisted man and other patients - one commissioned officer and one petty officer.
15. Record on Nursing Notes time of death, name of medical officer who pronounced death, and name of person who itemized personal effects.

POINTS TO EMPHASIZE

1. Check local Hospital Instructions for specific procedure.
2. Notify immediately all appropirate officers.
3. Use medical aseptic technique in handling linen, equipment and body if patient died of active communicable disease. Write COMMUNICABLE DISEASE in large letters on identification tags.
4. A morgue or shroud box containing all necessary supplies should be available to each ward.
5. Before initiating procedure, family should have opportunity to view body.

CARE OF EQUIPMENT

1. Replenish Morgue Box and stow in proper place.
2. Clean unit.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CARE OF UNIT UPON DISCHARGE OF PATIENT

PURPOSE

To provide a clean and sanitary environment for next patient.

EQUIPMENT

Basin of hot water
Soap or detergent
Cleaning cloths
Cleanser
Linen hamper
Complete set of linen

PROCEDURE

1. Strip bed:
    a. Remove pillow, strip and place on chair.
    b. Loosen and remove bed clothes.
    c. Remove the mattress cover. (Plastic covers are not removed. They are washed on the bed and wiped dry.)
    d. Place all soiled linen in hamper.
    e. Remove bed tags if on bed.
2. Wash bed, bedside locker and chair:
    a. Fill basin half full of hot water. Add soap or detergent as directed.
    b. Wipe mattress with damp cloth.
    c. Wash springs and coils. Raise the head and foot of bed and wash all rods under the springs and bed frame dry.
    d. Wipe pillow with damp cloth.
    e. Wash bedside locker. Empty drawer and wash.
    f. Wash chair.
3. Return wash basin, bed pan, emesis basin, etc. to CSR if sterilization is necessary. Discard disposable items.
4. Make bed. Straighten unit. Empty wastebaskets.
5. Swab the deck.

CARE OF UNIT UPON DISCHARGE OF PATIENT (Continued)

POINTS TO EMPHASIZE

1. Two people can remove and put on a mattress cover easier than one person. Seek assistance.
2. Do NOT use washclothes or towels for cleaning.
3. Use care in removing bed linen. Lift mattress with one hand; pull out linen with other hand.
4. Cotton blankets are sent to the laundry with other linen. Check local hospital policy for the care of wool blankets.
5. Pillows should be protected with a plastic cover. Unprotected soiled pillows are sent to the laundry and handled according to local hospital policy.

CARE OF EQUIPMENT

Wash, rinse and dry basin. Put away equipment.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

III

ASSISTING WITH THERAPEUTIC MEASURES

TABLE OF EQUIVALENTS

WEIGHTS

Metric	Approximate Apothecary
30. Gm.	1 oz
1. Gm.	15 gr.
0.1 Gm.	1 1/2 gr.
60. mg.	1 gr.
30. mg.	1/2 gr.
15. mg.	1/4 gr.
10. mg.	1/6 gr.
8. mg.	1/8 gr.
0.6 mg.	1/100 gr.
0.4 mg.	1/150 gr.
0.3 mg.	1/200 gr.

LIQUID MEASURES

1000 cc.	1 qt.
500 cc.	1 pt.
32 cc.	1 fl. oz.
16 cc.	1/2 fl. oz.
5 cc.	1 fl. dr.
1 cc.	15 minims

ADMINISTRATION OF ORAL MEDICATIONS

PURPOSE

To promote health
To cure disease
To relieve pain or discomfort

EQUIPMENT

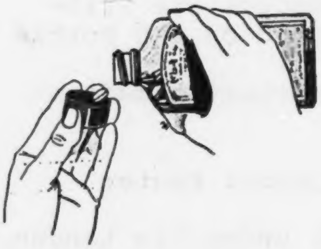
Medicine tray or cart
Disposable medicine cups or souffle cups
Teaspoons
Paper cups
Paper wipes
Pitcher of water
Drinking tubes or straws
Medication cards

PROCEDURE

1. Wash hands.
2. Unlock medicine cabinet.
3. Assemble all medicine cards to be used for the specific time.
4. Arrange cards in sequence similar to placement of the patients on the ward. Place cards face down.
5. Take first card. Locate and remove medicine from shelf.
6. Read label. Compare label with card.
7. Place medicine in disposable medicine cup or souffle cup and place on tray with card. Read label.
8. Wipe rim of bottle if liquid medication is being poured. Return to shelf reading label for third time.
9. Repeat steps 5 - 8 until all medicines are poured.
10. Carry tray to ward.
11. Identify patient:
    a. READ bed tag - compare with medicine card.
    b. Check patient's identification bracelet with medicine card.
    c. Ask patient his name. Compare with medicine card.

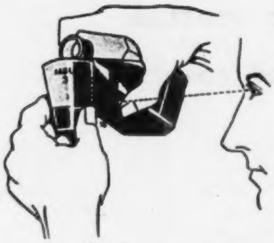
ADMINISTRATION OF ORAL MEDICATIONS (Continued)

PROCEDURE (Continued)



Removing Tablet From Bottle.

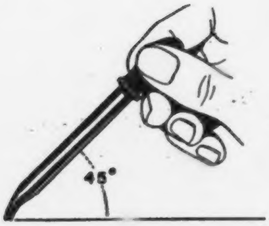
12. Give medication to patient. Give water unless contraindicated.
13. Stay with patient until medication has been taken.
14. Place disposable medicine cup or souffle cup to one side of tray. Turn medicine card face down on tray.
15. Repeat steps 11 - 14 for remaining medications.
16. To chart medications, follow the instructions for Medication Administration Record, pages 128 A and B.
17. Unusual or specific patient response to medications should be recorded on the Nursing Notes (SF 510).
18. Return medications cards to board in correct order.
19. When a medication is discontinued, the card is destroyed, the order is crossed off the Nursing Care Plan I (NavMed 6550/1). On the Medication Administration Record (MAR), cancel out and bracket remaining squares for that day, follow with "stopped", date and initials.



-Pouring Liquid Medication.

POINTS TO EMPHASIZE

1. Discontinue conversation with others while checking medication cards and preparing medications.
2. Never give a medication from an unlabeled bottle or one that is illegibly marked.
3. Do not give a medication prepared by another person.
4. Pills, tablets or capsules must not be touched with hands. Transfer correct dosage from bottle cap to medicine glass.
5. In giving powders, measure with a spoon into a medicine glass, add water and stir.
6. In pouring liquids, always be sure to read directions on bottle and pour away from the side which is labeled. Clean top of bottle with paper wipes.
7. Liquids should be measured at eye level.
8. Irons, acids and iodines are given after meals, well diluted and through a drinking tube.



-Correct Angle of Medicine Dropper.

ADMINISTRATION OF ORAL MEDICATIONS (Continued)

POINTS TO EMPHASIZE (Continued)

9. Cough medicines are given after all other medications are taken and are administered undiluted and not followed by water.
10. Pills should not be left at the bedside unless so specified by Medical Officer's orders.
11. Refer to Table of Equivalents, when orders are written in a different system than that used on the bottle or vial of medication.
12. Do not smoke while preparing or administering medications.

NOTE: In giving medications by the sublingual route:

1. Instruct the patient to place the pill under his tongue and allow it to dissolve.
2. No water should be taken with medication.

CARE OF EQUIPMENT

1. Discard disposable medicine cups and/or souffle cups.
2. Clean rest of equipment as necessary and reset tray.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ADMINISTRATION OF SUBCUTANEOUS INJECTION

PURPOSE

To introduce a small amount of drug in sterile solution under the skin.

EQUIPMENT

Sterile syringe
Prescribed medication
Sterile needle 23 gauge 3/4" length
Alcohol sponges
Ampule of sterile saline
Ampule file
Sterile 2 x 2 gauze sponges

PROCEDURE

1. Wash hands.
2. Read medication card carefully for name of medication and dosage.
3. Procure medication and read label 3 times.
4. Prepare medication as follows:
    a. Assemble syringe and needle using aseptic technique.
    b. Prepare medication in the following manner:
        (1) If medication is in an ampule:
            (a) Wipe file and neck of ampule with alcohol sponge.
            (b) File neck of ampule.
            (c) Wrap ampule with gauze sponge and break off top.
            (d) Insert needle through opening and withdraw medication.
            (e) Discard ampule.
        (2) If medication is in rubber stoppered vial:
            (a) Cleanse top with alcohol sponge.
            (b) Inject amount of air into vial equal to amount of medication to be withdrawn.
            (c) Withdraw prescribed amount of medication.
            (d) Pull needle out of rubber stopper.
        (3) If medication is in tablet form:
            (a) Remove tablet from container and place in syringe using aseptic technic.

ADMINISTRATION OF SUBCUTANEOUS INJECTION (Continued)

PROCEDURE (Continued)

3\.
   - (b) Cleanse and open ampule of sterile saline in manner described in b. (1) (a) through (e), withdrawing 1 cc of solution.
   - (c) Rotate syringe gently to dissolve tablet.
   - (d) Cover needle with disposable needle sheath.
   - (e) Place syringe and alcohol sponge on tray with medication card and take to patient's bedside.

5. Identify patient:
   a. READ bed tag and check with medication card.
   b. CHECK identification band with medication card.
   c. Ask patient his name. Compare with card.
6. Tell patient what you are going to do.
7. Cleanse site of injection with alcohol sponge.
8. Hold syringe upright. Expel air bubbles.
9. Grasp arm firmly at either side of injection site with thumb and forefinger of left hand. Lift up tissue to form cushion.
10. Insert needle quickly at 45 degree angle.
11. Draw back on plunger. If no blood appears in syringe, inject solution without force. (If blood appears, remove needle and apply pressure).
12. Place alcohol sponge over needle. Remove needle quickly. Massage site of injection unless contraindicated.
13. Record medication and site of injection on Medication Administration Record (MAR).

POINTS TO EMPHASIZE

1. Identify patient by identification band, bed tag, and asking patient his name.
2. For tablets difficult to dissolve, heat ampule of sterile saline in basin of hot water before using.

CARE OF EQUIPMENT

1. Break off tips of needle and syringes.
2. Dispose of needle and syringe according to local instruction.

ADMINISTRATION OF SUBCUTANEOUS INJECTION (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ADMINISTRATION OF INTRAMUSCULAR INJECTION

PURPOSE

To introduce a small amount of medication into the muscle.

EQUIPMENT

Sterile syringe
Prescribed medication
Sterile needle, 21 gauge 1 1/4" length
Alcohol sponges
Ampule of Sterile Saline
Ampule file
Sterile 2 x 2 gauze sponges

PROCEDURE

1. Read medication card carefully for medication and dosage.
2. Procure medication and read label three times.
3. Assemble syringe and needle and prepare medication using aseptic technique as described on page 120, subcutaneous injection procedure.
4. Place syringe and alcohol sponge on tray with medication card and take to bedside.
5. Identify patient:
   a. READ bed tag and compare with medication card.
   b. CHECK identification band with medication card.
   c. ASK patient his name. Compare with card.
6. Tell patient what you are going to do.
7. Cleanse site of injection with alcohol sponge.
   a. Lateral thigh.
   b. Upper outer quadrant of the buttock.
   c. Deltoid muscle.
8. Hold syringe upright and expel air bubbles.
9. Make firm cushion of flesh at injection site; insert the needle quickly at a 90° angle.
10. Draw back on plunger and if no blood appears in syringe, slowly inject medication.
11. Place alcohol sponge over site of injection. Quickly remove needle. Massage site of injection unless contraindicated.
12. Record medication and site of injection on Medication Administration Record (MAR).

POINTS TO EMPHASIZE

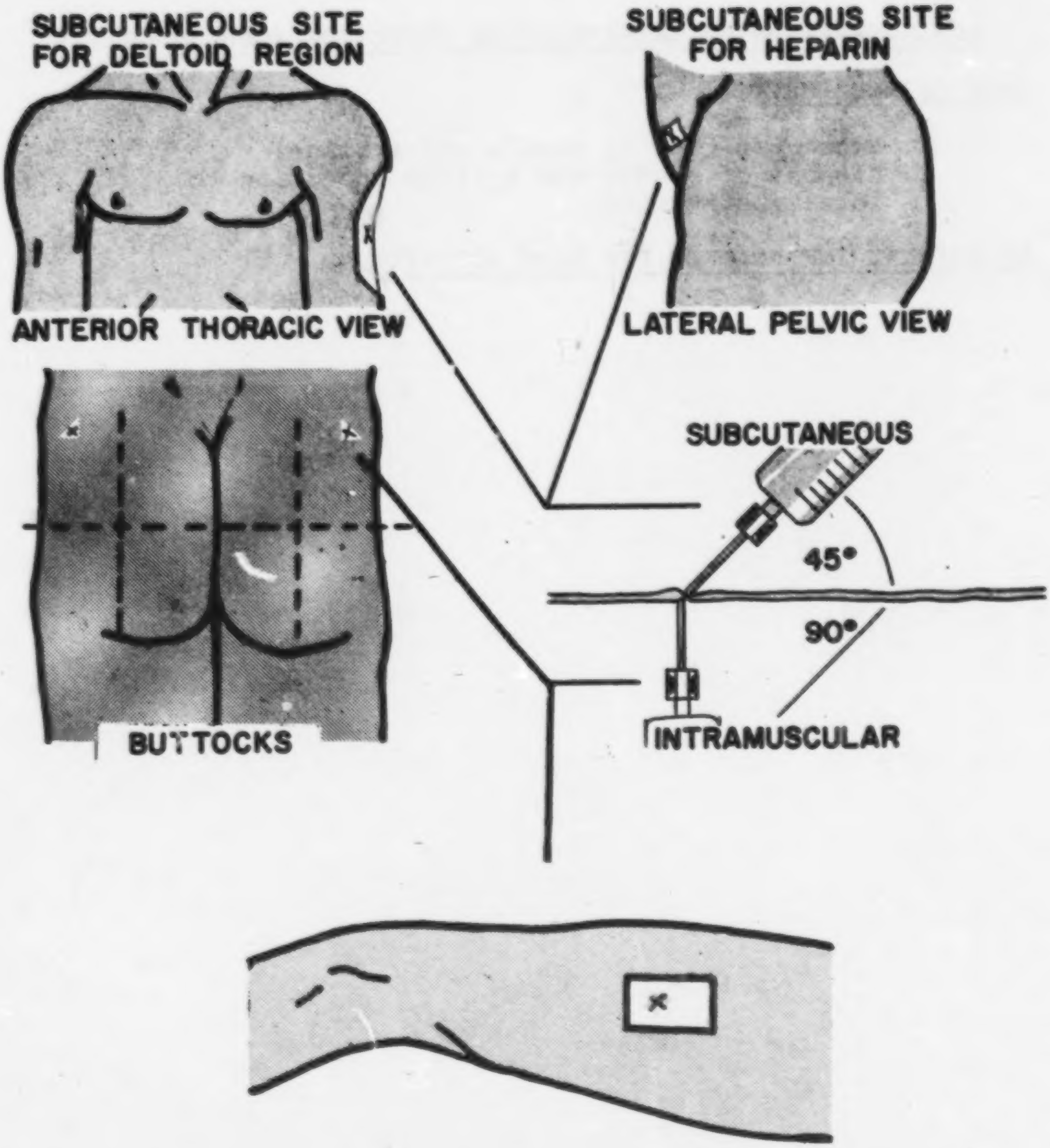
1. Check directions on "DRUG CIRCULAR" for administration and information.

ADMINISTRATION OF INTRAMUSCULAR INJECTION (Continued)

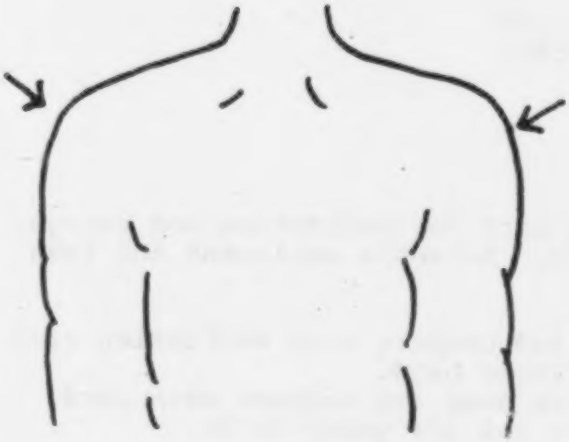
CARE OF EQUIPMENT

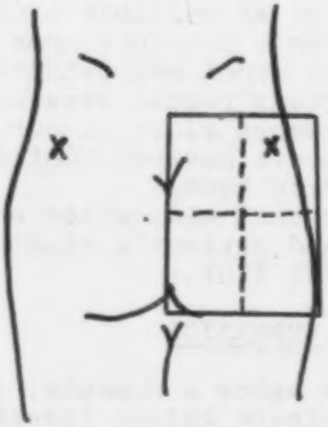
1. Break off tips of needle and syringe.
2. Dispose of needle and syringe according to local instruction.

ADDITIONAL INFORMATION FOR THIS ACTIVITY


SUBCUTANEOUS SITE FOR DELTOID REGION
SUBCUTANEOUS SITE FOR HEPARIN
ANTERIOR THORACIC VIEW
LATERAL PELVIC VIEW
SUBCUTANEOUS
45°
90°
BUTTOCKS
INTRAMUSCULAR
MID-PORTION VASTUS LATERALIS

SITES OF INTRAMUSCULAR INJECTIONS


DELTOID MUSCLE


Outer Quadrant of Buttock

ADMINISTRATION OF SUPPOSITORIES AND OTHER SOLID RECTAL MEDICATIONS

PURPOSE

To introduce a medication per rectum in order to produce a local and/or systemic effect.

EQUIPMENT

Medication
Rectal glove/finger cot
Water soluble lubricant
Toilet tissue
Paper towels

PROCEDURE

1. Check medication card for medication and dosage.
2. Obtain medication. Assemble equipment and take to bedside.
3. Identify patient.
    a. READ bed tag and compare with medication card and identification band.
    b. ASK patient his name and compare with card.
4. Tell patient what you are going to do.
5. Have patient turn on side.
6. Put on rubber glove or finger cot.
7. Expose rectum.
8. Lubricate medication if necessary.
9. Insert medication gently into rectum. Advance it as far as possible with the index finger.
10. Apply pressure over anus until patient has no desire to expel medication.
11. Clean rectal area with toilet tissue.
12. Remove glove or cot. Place in paper towel.
13. Leave patient comfortable.
14. Wash hands.
15. Record medication on Medication Administration Record and patient's response to medication on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

When using a capsule, perforate both ends with a pin. Lubricate before inserting.

ADMINISTRATION OF SUPPOSITORIES AND OTHER SOLID RECTAL MEDICATIONS (Continued)

CARE OF EQUIPMENT

Discard disposable glove or finger cot.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

INSTRUCTIONS FOR MEDICATION ADMINISTRATION RECORD

PURPOSE

To provide a complete, concise record of patient's past and present medications.

GENERAL INFORMATION

1. Insert identifying data in lower left corner of MAR using addressograph plate.
2. Scheduled medication orders are transcribed on front of MAR from Doctors Orders; single order, preoperative, variable dose and PRN medications are entered on back of MAR from the Medication-Treatment card after administration.
3. If kept elsewhere return MAR to patient's chart when:

    a. Filled for a seven-day period on either side
    b. Patient is discharged or placed on rehabilitation status with all medications discontinued
    c. Patient is transferred to another ward
    d. Patient is referred for consultation to another service, department or clinic

RECORDING OF SCHEDULED MEDICATIONS

1. Order Date column: Enter date (month, day, year) order is written.

2. Medication column: Enter medication, dosage frequency, route of administration and any special precautions.

3. Hours column: Start with earliest military time after 2400 and list vertically the hour or hours medication is to be given. Use a new line for each dose given. Separate medications by drawing a heavy line under last entry and across entire page. Enter next medication below last line used.

4. Dates Given column: On day order is written, enter month and date horizontally across page.

    a. All vacant squares preceding the first dose are cancelled out with an "X".
    b. When a medication is given every other day or for a specific number of days, cancel out all squares corresponding to the days it is not given.

INSTRUCTIONS FOR MEDICATION ADMINISTRATION RECORD (Continued)

RECORDING OF SCHEDULED MEDICATIONS (Continued)

After medication is given, enter initials in column below the appropriate date and across from the correct time. Enter initials, signature and title (LCDR, HN, RN, LPN) in Initial Code section.

Place an "L" in the proper date and time square, if medication was not given to a patient on liberty status. Make notation in Nursing Notes that patient is on liberty.

If a medication is not given for any reason other than liberty, place an asterisk (*) in the appropriate date and time square and enter note of explanation, preceded by an asterisk, in the Nursing Notes.

If a medication is discontinued, cancel out and bracket remaining squares for that day, follow with "STOPPED", date and initials.

UNIQUE ORDER MEDICATIONS

1. See sample MAR for recording Digitalis Preparations, Insulin Administration According to Sliding Scale and Anticoagulant Therapy.

2. Decreasing Dosage Medications

   In Medication column enter dosage, frequency, route of administration and duration; in Hours column the hours medication is to be given; and dose in the squares corresponding to correct hours.

   After medication is given, initials are noted in the square for appropriate date, time and dosage.

3. Q 1 Hour Medications

   Record medication. In Hours column use three lines to note the tour of duty hours: 0700 - 1500; 1500 - 2300; 2300 - 0700. At the completion of a tour of duty, individual responsible for giving q1h medications initials the appropriate square under the date. If any doses were omitted, put initials and an asterisk (*) in the square and a corresponding asterisk and explanation in the Nursing Notes.

INSTRUCTIONS FOR MEDICATION ADMINISTRATION RECORD (Continued)

UNIQUE ORDER MEDICATIONS (Continued)

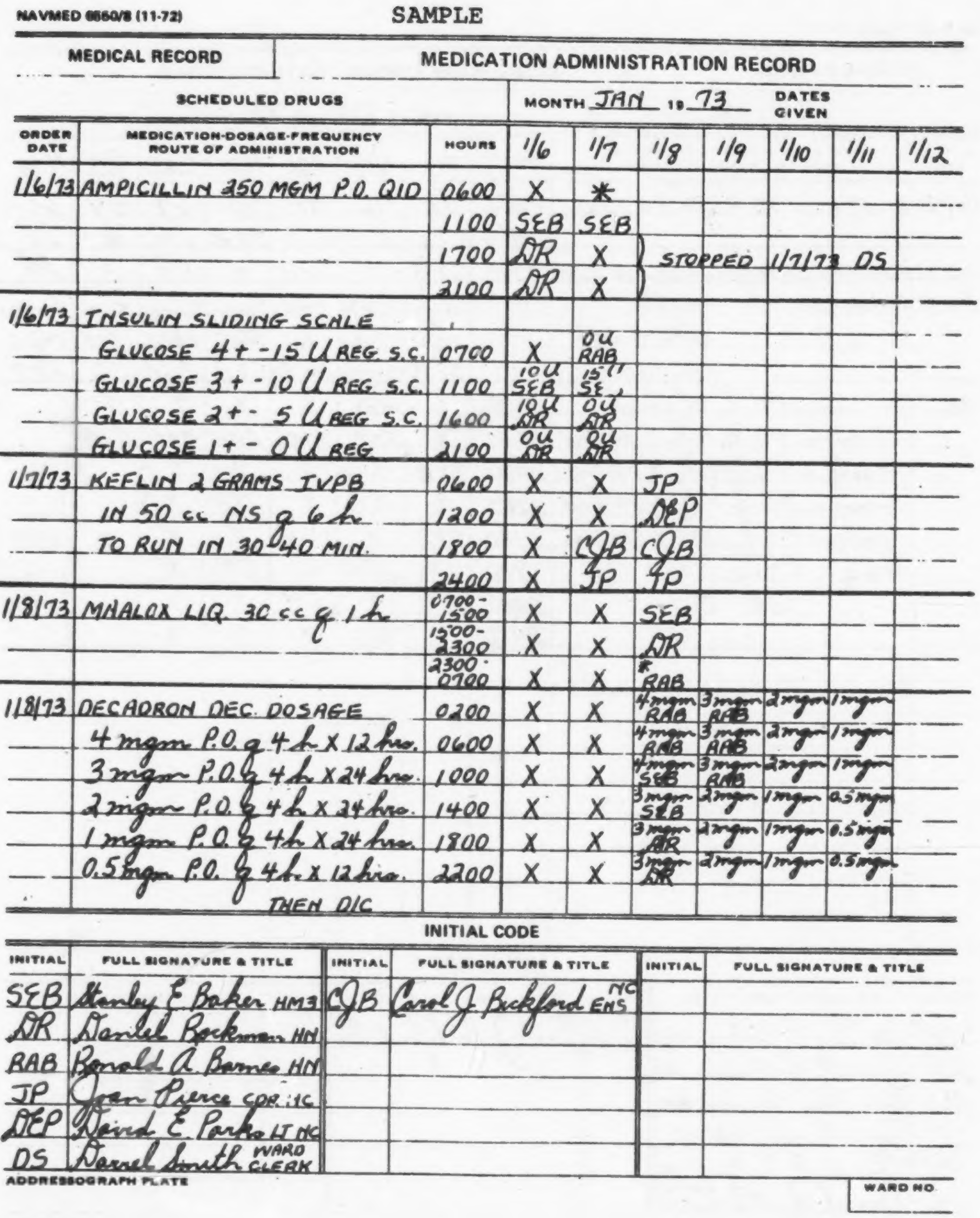
4. Q 2 Hour Medications

Record medication, dosage and route. Indicate whether it is given on odd or even hours. Fill in the Hour column in the same manner as for q1h medications.

RECORDING OF OTHER MEDICATIONS

For Single Order, Preoperative, PRN, and Variable Dose medications, follow instructions for recording scheduled medications and refer to Sample MAR.

ADDITIONAL INFORMATION FOR THIS ACTIVITY



NAVMED 6550/8 (11-72)

SAMPLE

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH JAN 19 73 — DATES GIVEN

ORDER DATE	MEDICATION-DOSAGE-FREQUENCY ROUTE OF ADMINISTRATION	HOURS	1/6	1/7	1/8	1/9	1/10	1/11	1/12
1/6/73	AMPICILLIN 250 MGM P.O. QID	0600	X	*					
		1100	SEB	SEB					
		1700	DR	X	STOPPED		1/7/73	DS	
		2100	DR	X					
1/6/73	INSULIN SLIDING SCALE								
	GLUCOSE 4+ - 15 U REG. S.C.	0700	X	0U RAB					
	GLUCOSE 3+ - 10 U REG. S.C.	1100	10U SEB	15" SE					
	GLUCOSE 2+ - 5 U REG S.C.	1600	10U DR	0U DR					
	GLUCOSE 1+ - 0 U REG	2100	0U DR	0U DR					
1/7/73	KEFLIN 2 GRAMS IVPB	0600	X	X	JP				
	IN 50 cc NS q 6 h.	1200	X	X	DEP				
	TO RUN IN 30-40 MIN.	1800	X	CJB	CJB				
		2400	X	JP	JP				
1/8/73	MAALOX LIQ. 30 cc q 1 h.	0700-1500	X	X	SEB				
		1500-2300	X	X	DR				
		2300-0700	X	X	* RAB				
1/8/73	DECADRON DEC. DOSAGE	0200	X	X	4 mgm RAB	3 mgm RAB	2 mgm	1 mgm	
	4 mgm P.O. q 4 h. x 12 hrs.	0600	X	X	4 mgm RAB	3 mgm RAB	2 mgm	1 mgm	
	3 mgm P.O. q 4 h. x 24 hrs.	1000	X	X	4 mgm SEB	3 mgm RAB	2 mgm	1 mgm	
	2 mgm P.O. q 4 h. x 24 hrs.	1400	X	X	3 mgm SEB	2 mgm	1 mgm	0.5 mgm	
	1 mgm P.O. q 4 h. x 24 hrs.	1800	X	X	3 mgm DR	2 mgm	1 mgm	0.5 mgm	
	0.5 mgm P.O. q 4 h. x 12 hrs.	2200	X	X	3 mgm DR	2 mgm	1 mgm	0.5 mgm	
	THEN D/C								

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
SEB	Stanley E Baker HM3	CJB	Carol J. Bickford ENS NC		
DR	Daniel Rockman HN				
RAB	Ronald A. Barnes HN				
JP	Joan Pierce CDR NC				
DEP	David E. Parks LT NC				
DS	Darrel Smith WARD CLERK				

ADDRESSOGRAPH PLATE

WARD NO.

SINGLE DOSE,
PRE-OP PRN
& VARIABLE
DOSE ORDERS
SEE REVERSE

SAMPLE

NAVMED 6550/8 (11-72)

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS

MONTH JAN 19 73 DATES GIVEN

ORDER DATE	MEDICATION-DOSAGE-FREQUENCY ROUTE OF ADMINISTRATION	HOURS	1/18	1/19	1/20	1/21	1/22	1/23	1/24
1/18/73	DIGOXIN 0.25 mgm P.O. qd	PULSE	78	76	78	70	64	56	66
		0900	SEB	SEB	SEB	SEB	DR	*	DR
1/18/73	ESIDRIX 50 mgm P.O. qod (EVEN)	0900	SEB	X	SEB	X	DR	X	DR
1/18/73	COUMADIN DOSAGE	—	10 mgm	7.5 mgm	NONE	5 mgm	7.5 mgm	10 mgm	5 mgm
	TIME GIVEN	—	1400	1400	X	1445	1430	1415	1400
	INITIALS	—	SEB	SEB	SEB	SEB	CJB	JP	DEP
1/18/73	DECADRON DEC. DOSAGE	0200	X	RAB	X	X	X	X	
	4 mgm P.O. q 4h X 24 hrs.	0600	X	RAB	RAB	RAB	RAB	RAB	
	4 mgm P.O. q 6h X 24 hrs.	1000	SEB	X	X	X	X		
	4 mgm P.O. q 8h X 24 hrs.	1200	X	SEB	X	X	X		
	4 mgm P.O. q 12h X 24 hrs.	1400	SEB	X	SEB	X	X		STOPPED
	4 mgm P.O. qd X 1	1800	DR	DR	X	DR	X		1/23/73
	THEN D/C	2200	DR	X	DR	X	X		RAB
		2400	X	RAB	X	X	X		

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
SEB	Stanley E Baker HM3	CJB	Carol J. Bickford NC ENS		
DR	Daniel Rockman HN				
RAB	Ronald A Barnes HN				
JP	Joan Pierce CDR NC				
DEP	David E Parks LT NC				
DS	Darrel Smith WARD CLERK				

ADDRESSOGRAPH PLATE

WARD NO

SINGLE DOSE,
PRE-OP PRN
& VARIABLE
DOSE ORDERS
SEE REVERSE

SAMPLE

MEDICATION ADMINISTRATION RECORD (Back)

SINGLE ORDERS – PRE-OPERATIVE

MEDICATION-DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION-DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL
DUCOLAX SUPP. T	1/9/73	2100	DR				
"PRE-OP"							
DEMEROL 50mg							
ATROPINE 0.4 mg IM	1/10/73	0600	JP				
PHENERGAN 25mg							
ERROR DEP ~~LASIX 40 mg I.V PUSH~~	~~1/10/73~~	~~1200~~	~~DEP~~				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
1/6/73	VALIUM 5-10mg	DATE	1/6	1/6	1/7													
	P.O. q 3-4 hrs.	TIME	1520	2030	0430	STOPPED 1/7/73 DS												
	PRN RESTLESSNESS	DOSE	5mg	10mg	10mg													
		INIT	DR	RAB	RAB													
1/7/73	PHENAPHEN #3	DATE	1/7	1/7	1/7	1/8	1/8	1/8	1/9									
	CAPS Ṫ-π̈ q 3-4h	TIME	1015	1300	1930	0400	1200	2310	1130									
	PRN PAIN	DOSE	Ṫ	π̈	π̈	π̈	Ṫ	Ṫ	Ṫ									
		INIT.	SEB	SEB	DR	RAB	SEB	RAB	DEP									
1/10/73	DEMEROL 100 mg	DATE	1/10	1/10														
	IM q 3h PRN	TIME	1400	1730														
	SEVERE PAIN	DOSE	100mg	100mg														
		INIT.	DEP	CJB														
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

ADMINISTRATION OF MOISTURIZED OXYGEN THERAPY TO PATIENT WITH TRACHEOSTOMY TUBE

PURPOSE

To administer moisturized oxygen in higher concentration than is available in the atmosphere.

EQUIPMENT

Oxygen supply with nebulizer
Tracheostomy mask
Large bore oxygen tubing
"No Smoking" sign

PROCEDURE

1. Wash hands.
2. Explain procedure to patient.
3. Turn oxygen supply onto prescribed volume.
4. Place tracheostomy mask over tracheostomy tube. Secure mask in place.
5. Connect large bore oxygen tubing to tracheostomy mask. Connect other end of tubing to oxygen supply and nebulizer.
6. Observe precautions as required for any oxygen administration.

POINTS TO EMPHASIZE

1. Warm, dry air is irritating to the tracheal mucosa. During oxygen therapy a nebulizer must be used.
2. Do not fasten mask too tightly around stoma and neck.
3. Tubing should be emptied of moisture periodically as necessary.
4. The tracheostomy mask is made of clear plastic and has an unstoppered hole for suctioning the patient.
5. Tubing and mask should be changed at least weekly.

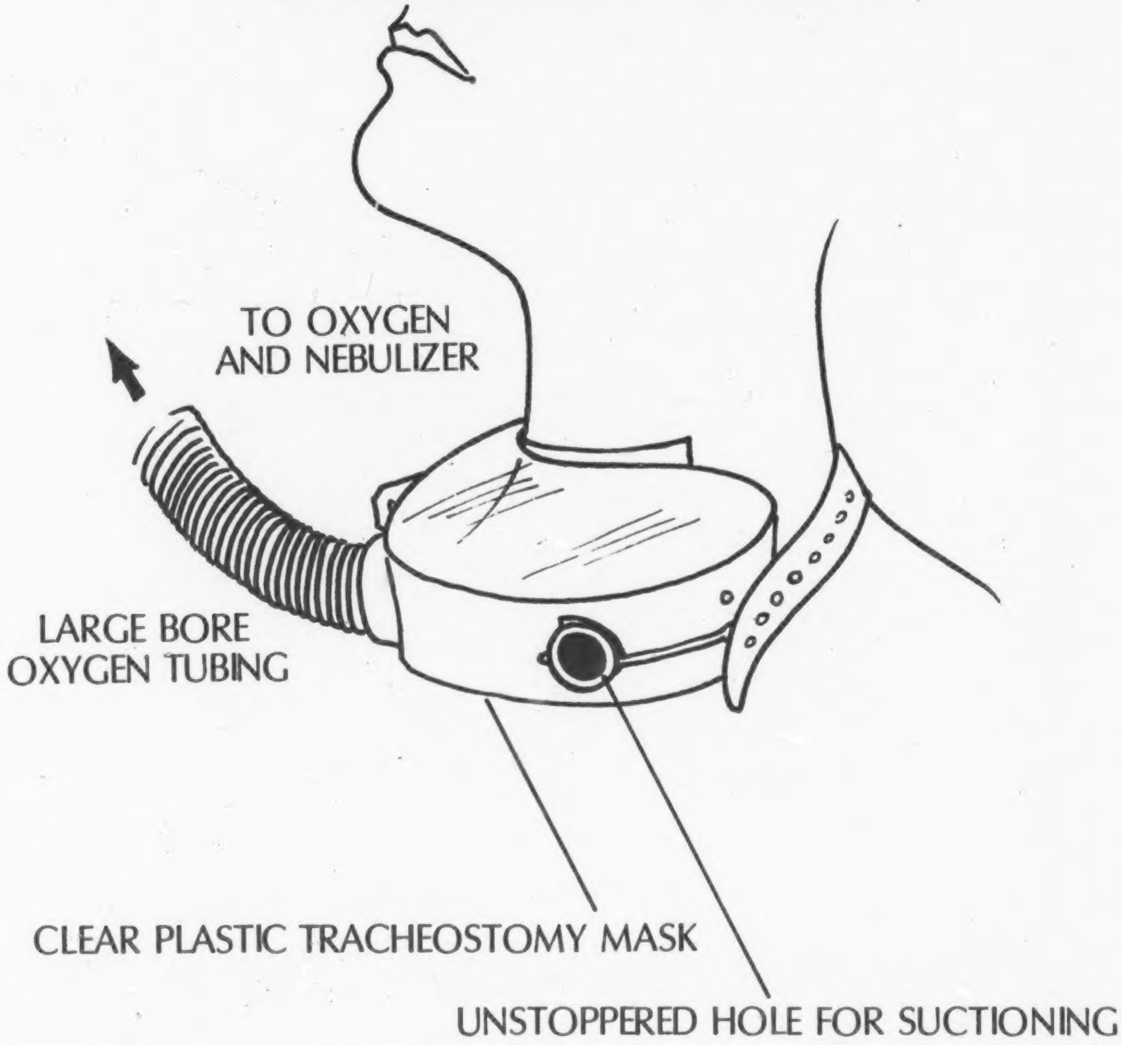
CARE OF EQUIPMENT

1. Turn off oxygen.
2. Detach tubing from oxygen supply and nebulizer.
3. Clean equipment according to local hospital policy.

ADMINISTRATION OF MOISTURIZED OXYGEN THERAPY TO PATIENT WITH TRACHEOSTOMY TUBE Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TRACHEOSTOMY MASK FOR ADMINISTRATION OF MOISTURIZED OXYGEN


TO OXYGEN AND NEBULIZER
LARGE BORE OXYGEN TUBING
CLEAR PLASTIC TRACHEOSTOMY MASK
UNSTOPPERED HOLE FOR SUCTIONING

STEAM INHALATIONS

PURPOSE

To introduce plain or medicated steam into the upper respiratory tract.
To relieve congestion.

EQUIPMENT

Vaporizer
Medication if ordered
Water

PROCEDURE

1. Tell patient what you are going to do.
2. Close room windows and doors.
3. Fill bottle on vaporizer to the water line.
4. Place medication in vaporizer cup as ordered.
5. Roll vaporizer to bedside. Place 3-prong safety plug into grounded wall outlet.
6. Turn vaporizer on. Direct steam toward the patient's head.
7. Continue treatment as ordered.
8. Record time, medication used, and effect of treatment on patient.

POINTS TO EMPHASIZE

1. Prevent burning the patient. Keep vaporizer 12 - 18 inches away from the patient.
2. Check water level frequency so that the bottle does not become empty.

CARE OF EQUIPMENT

1. Empty water jar and medication cup, and wash thoroughly.
2. Recoil cord around handle of vaporizer.
3. Return to proper storage place.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ADMINISTRATION OF INTRAVENOUS FLUIDS

PURPOSE

To introduce large amounts of fluid into the vein.
To supply medication and fluids to the body.
To increase the blood volume.
To supply nourishment to the body.

EQUIPMENT

I.V. Standard
Solution and medications ordered
Tray with:
- Disposable intravenous set
- Sterile needles in individual packages
  - Two 18 gauge, 1 1/2" length for airway
  - Two 20 gauge, 1 1/2" length
  - Two 21 gauge, 1 1/4" length
  - Two 19 gauge, butterfly needles
  - Two 21 gauge, butterfly needles
  - Two 16 gauge, medicut needles
  - Two 18 gauge, medicut needles
  - Two 20 gauge, medicut needles
- Roll of adhesive tape, scissors
- Roll of 2" or 3" gauze bandage
- Sterile 5 cc. syringe
- Sterile 2 cc. syringe
- Alcohol sponges
- Ampule file
- Tourniquet
- Curved Basin
- Padded arm board

PROCEDURE

1. Tell patient what you are going to do. Make him comfortable. Remove pajama sleeve from arm to be used.
2. Wash hands.
3. Prepare equipment:
   a. Obtain prescribed solution. Hold bottle to light. Solution should be clear and without sediment. Remove metal collar and cap from bottle top. Wipe top with alcohol sponge.

ADMINISTRATION OF INTRAVENOUS FLUIDS (Continued)

PROCEDURE (Continued)

3.
   - b. If medication is to be added to solution:
     - (1) Before adding any medication, ascertain that it is one that may be administered by nursing service personnel.
     - (2) Draw correct amount of medication into sterile syringe and inject into bottle or give to ward medical officer to inject.
     - (3) Label bottle with patient's name and amount of medication added.
   - c. Place needle in airway outlet if required.
   - d. Remove the protective cap from drip regulator. Insert drip regulator into large depression of the rubber stopper.
   - e. Hang bottle on standard.
   - f. Put the tourniquet in place - do not tighten.
   - g. Cleanse site of injection with alcohol sponge.
   - h. Remove protective cap from needle adapter. Allow solution to run through tubing into curved basin until all air bubbles have been expelled. Clamp tubing.
   - i. Attach selected needle.
   - j. Tighten tourniquet.
   - k. The needle is inserted into vein.
   - l. Release tourniquet and unclamp tubing.
   - m. Regulate the flow as ordered.
     - (1) Calculation of drops per minute when the ward medical officer specifies a time limit.
       - (a) Amount of solution divided by hours equals cc's/hour.
       - (b) cc's/hour divided by 60 minutes equals cc's/minute.
       - (c) cc's/minute multiplied by 15 drops equals drops/minute.
   - n. Secure the needle in place with adhesive strips and pad needle hub with cotton as needed.

ADMINISTRATION OF INTRAVENOUS FLUIDS (Continued)

PROCEDURE (Continued)

4. If more than one bottle of fluid is ordered:
    a. Obtain the prescribed solution and check label with order.
    b. Remove metal collar and cap. Wipe top with alcohol sponge. Insert needle in airway outlet.
    c. Clamp tubing. Remove drop regulator from original bottle. Insert into new bottle.
    d. Unclamp tubing and adjust flow.
5. When treatment is completed:
    a. Clamp tubing.
    b. Remove adhesive tape.
    c. Place sterile alcohol sponge over needle. Withdraw needle. Apply pressure over site of injection until bleeding stops.
    d. Gently flex forearm to exercise muscles.
6. Record:
    a. In Nursing Notes:
        (1) Time therapy was started with the type and amount of solution and medication administered and by whom started.
        (2) Time therapy was discontinued and any unusual observations or occurrences while fluids were being administered.
    b. On Intake and Output sheet:
        (1) Time started and solution and amount absorbed.

POINTS TO EMPHASIZE

1. Hold solution bottle up to light before administering. Solution should be clear without sediment.
2. When needle is inserted into airway outlet, a rush of air should be heard entering the bottle. Do not use bottle if this is not heard.
3. Check solution and medication with Doctor's Orders for name, strength and amount of solution ordered. When medication is added to I. V. solutions, discoloration may appear. If cloudiness or clumps appear, do not use. Check with pharmacy.

POINTS TO EMPHASIZE

4. An armboard may be used to immobilize patient's arm if necessary.
5. Watch for signs of reaction or infiltration of fluids into tissues. If either occur, clamp tubing and notify the medical officer.
6. When blood is visible in plastic adapter or butterfly tubing the needle is in the vein.
7. Check frequently to determine if correct rate of flow is maintained and patient is comfortable.
8. If unable to start I.V. after two attempts, call for assistance.

CARE OF EQUIPMENT

1. Discard disposable equipment.
2. Restock I.V. tray.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

HYPODERMOCLYSIS

PURPOSE

To supply fluids to the body.

EQUIPMENT

- I.V. Standard
- Solution ordered
- I.V. Tray with:
  - Disposable Hypodermoclysis set
  - Alcohol sponges
  - Sterile needles in individual packages
    - Two - 22 gauge, 3" length
    - One - 18 gauge, 1 1/2" length for airway
  - Adhesive tape
  - Sterile 4 x 4 gauze sponges
- Curved Basin
- Sheet
- Protective pads
- Bandage scissors

PROCEDURE

1. Wash hands.
2. Tell patient what you are going to do. Make him comfortable.
3. Prepare equipment:
   a. Obtain prescribed solution. Hold bottle to light. Solution should be clear and without sediment. Remove metal collar and cap from bottle top.
   b. Wipe top with alcohol sponge.
   c. Place needle in airway outlet if required.
   d. Remove protective cap from the drip regulator. Insert drip regulator into large depression in rubber stopper.
4. Arrange linen to expose sites of injection.
   a. Place folded sheet over chest, abdomen, and mid thighs.
   b. Fan fold top linen to the level of patient's knees.
   c. Place protective pads under patient from level of hips to knees.

HYPODERMOCLYSIS (Continued)

PROCEDURE (Continued)

5. Hang bottle on standard.
6. Cleanse sites of injection with alcohol sponges. Leave sponges in place.
7. Remove protective caps from needle adapters and allow solution to run through tubing until all air bubbles have been expelled.
8. Attach needles. Allow solution to run through. Clamp tubing.
9. Insert needles into subcutaneous tissues of anterior thighs.
10. Place sterile 4 x 4 dressing around the hubs of needles.
11. Unclamp tubing and regulate flow at rate ordered.
12. If additional fluid is ordered:
    a. Obtain prescribed solution.
    b. Remove metal collar and cap. Wipe top with alcohol sponge. Insert airway needle.
    c. Clamp tubing. Remove drip regulator from original bottle. Insert into new bottle.
    d. Unclamp tubing. Adjust flow at rate ordered.
13. Clamp tubing when solution has been administered. Remove needles. Cover sites of injection with dry sterile dressing.
14. Record:
    a. In Nursing Notes: Time started and discontinued; type and amount of solution administered; site used; and by whom started and discontinued.
    b. On Intake and Output sheet: Time, solution and amount administered.

POINTS TO EMPHASIZE

1. Hold solution bottle up to light. Solution should be clear without sediment.
2. When needle is inserted into the airway outlet, a rush of air entering the bottle should be heard.
3. Watch the site of injection. If area becomes hard, blanched or painful, clamp tubing until the fluid is absorbed and then reopen clamp.

HYPODERMOCLYSIS (Continued)

POINTS TO EMPHASIZE (Continued)

4. Allow solution to drip no faster than the rate ordered.
5. This procedure is intended to be utilized for adults. Hypodermoclysis for infants and children are administered by the ward medical officer.

CARE OF EQUIPMENT

1. Rinse non-disposable needles in cold water and send to C.S.R.
2. Break off tips of disposable needles and discard according to local policy.
3. Discard other disposable equipment.
4. Restock tray.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

IVAC I.V. PUMP

PURPOSE

To deliver intravenous fluids at an accurate number of drops per minute utilizing an electronic sensing device.

EQUIPMENT

IVAC Pump
Drip chamber adaptor and sensor
Prepared I.V. fluids
Necessary I.V. tubing
I.V. standard

PROCEDURE

1. Wash hands.
2. Prepare I.V. fluids as described in directions for intravenous therapy, page 136.
3. Plug IVAC pump into 3-pronged grounded outlet.
4. Attach drop sensor and drip chamber adaptor to drip chamber.
5. Lift pump latch release handle and place I.V. tubing between tubing guide posts so that flow direction is left to right.
6. Close and latch release handle.
7. Unclamp I.V. tubing.
8. Turn drops-per-minute digits to desired number of drops.
9. Turn on power switch.
10. Depress start button.

POINTS TO EMPHASIZE

1. IVAC will alarm and shut off if bottle runs dry or if selected infusion rate cannot be maintained.
2. Check for infiltration freqeuently. The IVAC is a high pressure pump and will not shut off if infiltration occurs.
3. Always shut machine off to change flow rate.
4. Move tubing up or down at least once a day through guide posts to prevent undue strain or wearing out of tubing.

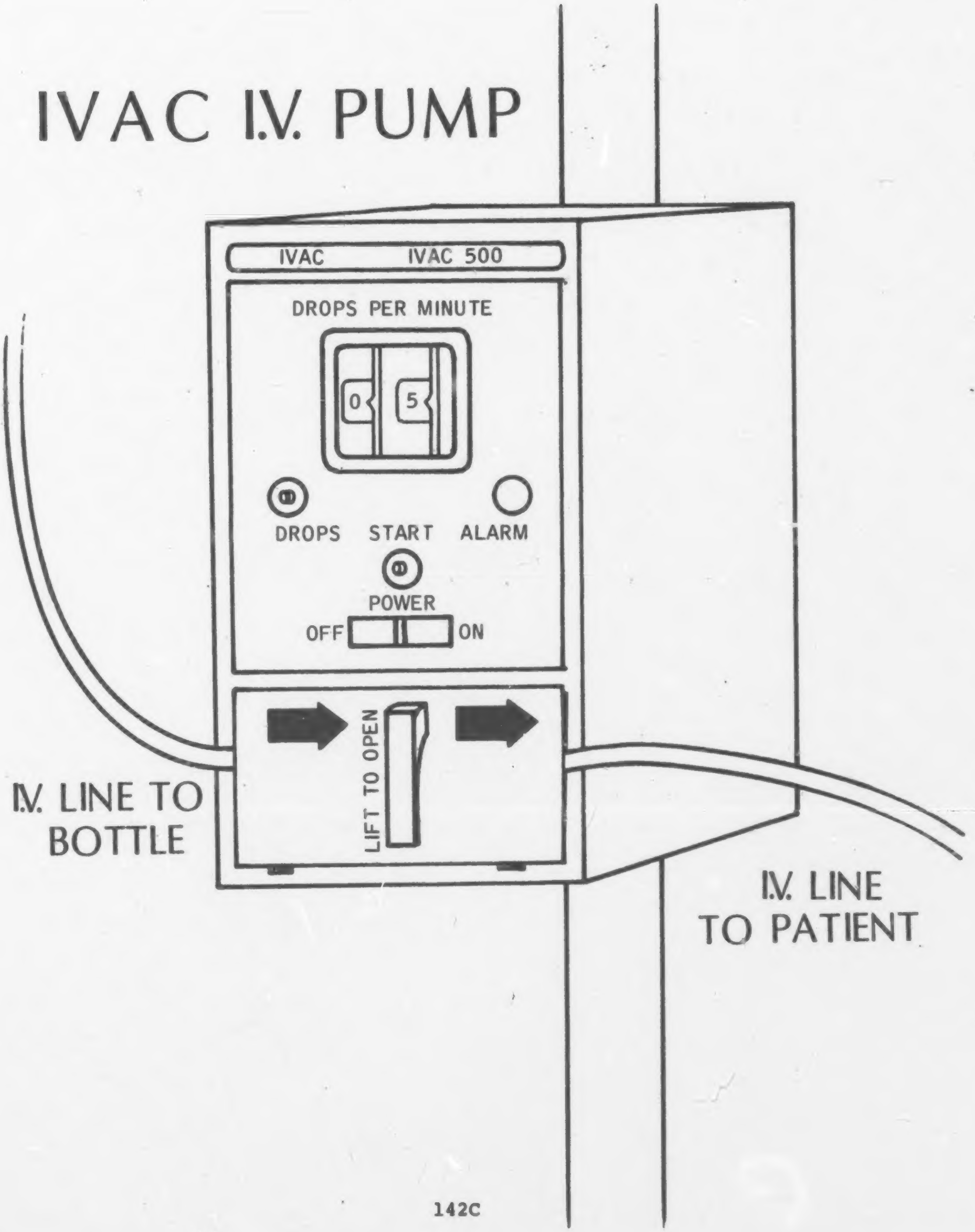
CARE OF EQUIPMENT

Discard disposable equipment.
Wipe IVAC pump off to prevent dust accumulation.

IVAC I.V. PUMP (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

IVAC I.V. PUMP


IVAC
IVAC 500
DROPS PER MINUTE
0
5
DROPS
START
ALARM
POWER
OFF
ON
LIFT TO OPEN
I.V. LINE TO BOTTLE
I.V. LINE TO PATIENT

ASSISTING WITH A BLOOD TRANSFUSION

PURPOSE

To increase blood volume or blood constituents to circulatory system.

EQUIPMENT

Unit of Blood
SF 518, Transfusion Form
I.V. Standard
I.V. Tray with:
  Disposable blood transfusion recipient set with filter sterile needles in individual packages
    Two 18 gauge, 1 1/2" length
    Two 20 gauge, 1 1/2"" length
    Two 16 gauge, medicut needles
    Two 18 gauge, medicut needles
    Two 20 gauge, medicut needles
    Sterile 2 cc. syringe
    Alcohol sponges
    Tourniquet
    Adhesive tape
    Roll of 2" - 3" gauze bandage
    Curved basin
    Padded arm board
    Scissors

PROCEDURE

1. Explain procedure to patient.
2. Obtain unit of blood from Blood Bank.
   a. Note time blood is received on ward.
   b. Check identification of patient verbally and by identification band and compare with name on blood tags.
   c. Compare number and information on identification tag of bottle or bag of blood and blood tag on patient's bed and wrist band. These must be the same. If there is any discrepancy in any of data, call the Blood Bank.
   d. Check number on blood bottle or bag with number on patient's Blood Transfusion Form (SF-518). These must be the same.

   e. All identification tags, bottles or bags of blood and SF-518 forms must be checked by the medical officer or an officer certified to start transfusion.

ASSISTING WITH A BLOOD TRANSFUSION (Continued)

PROCEDURE (Continued)

3. Wash hands.
4. Make patient comfortable. Remove pajama sleeve from arm to be used.
5. Wipe top of bottle with alcohol sponge. If bag of blood is used see assembling instructions (Page 148).
6. Puncture outlet diaphragm several times with a sterile 18 gauge needle. Insert needle into airway outlet.
7. Remove protective covering from filtered drip regulator and insert through diaphragm on bottle of blood.
8. Hang bottle on standard.
9. Remove protective covering from needle adapter. Allow blood to flow through tubing into basin.
10. Attach needle to needle adapter at end of tubing.
11. Assist medical officer by:
    a. Placing tourniquet on patient's arm.
    b. Cleansing site of injection with alcohol sponge.
12. Medical officer will make venipuncture.
13. Open clamp on tubing after medical officer releases the tourniquet.
14. Apply strips of adhesive tape to secure needle in place.
15. Regulate the flow of blood as prescribed by a medical officer.
16. Watch patient very closely for any untoward reaction to the transfusion.
17. Note date and hour transfusion was started on SF 518.
18. Upon completion of transfusion:
    a. Clamp tubing. Place sponge over needle and remove the needle. Apply pressure with sponge at site of puncture and flex forearm two or three times to exercise muscles. Make patient comfortable.
    b. Remove corresponding identification tag from bed and attach to empty bottle.
    c. Any untoward reaction is recorded on both copies of SF 518 by the medical officer.
    d. Attach duplicate SF 518 to bottle or bag and original to patient's chart.
    e. Return empty bottle or bag with tags and SF 518 to Blood Bank as prescribed locally.

ASSISTING WITH A BLOOD TRANSFUSION (Continued)

PROCEDURE (Continued)

18.
    f. Record:
        (1) On both copies of Blood Transfusion, (SF 518)
            (a) Date of Transfusion, time started and time completed/interrupted.
            (b) Amount received.
            (c) Reaction.
            (d) Signature of officer starting transfusion is required indicating that he has verified patient's identification.
        (2) On Intake and Output sheet (DD 792): Time started and amount of blood given.
        (3) On Nursing Notes: Date and time blood is started and completed, by whom started and discontinued, description of reaction if any, and amount given.

POINTS TO EMPHASIZE

1. Check patient's name on blood unit and number of the unit of blood with:
    a. Patient's wrist band.
    b. Blood tag on patient's bed or wrist in emergencies.
2. Blood is issued from the Blood Bank to Staff personnel ONLY.
3. Blood issued and not used shall be returned to the Blood Bank within one hour of issuing.
4. Blood shall NOT be stored in the ward refrigerators.
5. Transfusions are started by a medical officer or officers certified to start transfusions.
6. Watch patient closely for reaction: Hives, chills, malaise, pain in lower back, etc.
7. If a suspected reaction occurs:
    a. Clamp tubing to stop flow of blood.
    b. Notify the medical officer.
    c. Call Blood Bank immediately.
    d. Obtain urine specimen immediately.
    e. Take and record T.P.R.
    f. Record suspected reaction in Nursing Notes (SF 510).
    g. If blood transfusion is discontinued send blood bottle or bag and tubing with completed SF 518 to Blood Bank immediately.

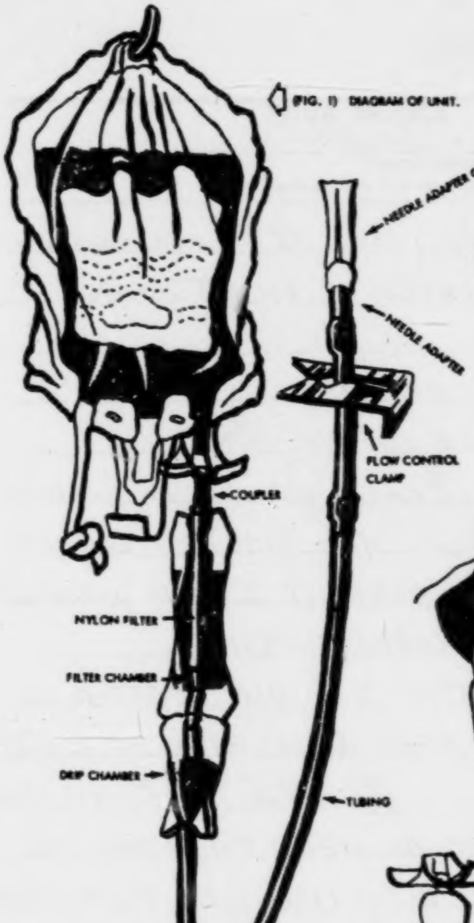
ASSISTING WITH A BLOOD TRANSFUSION (Continued)

CARE OF EQUIPMENT

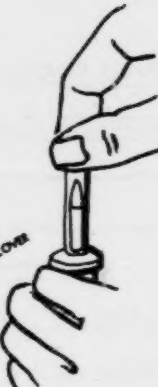
1. Break off tips of needles and syringes.
2. Discard needles and syringes according to local instruction.
3. Discard disposable set.
4. Restock I.V. tray.
5. Return used blood bag and completed SF 518 to Blood Bank.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

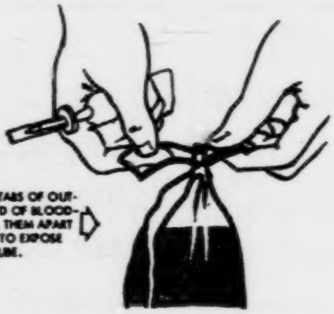
PREPARATION OF PLASTIC UNIT FOR TRANSFUSION


NEEDLE ADAPTER COVER
NEEDLE ADAPTER
FLOW CONTROL CLAMP
COUPLER
NYLON FILTER
FILTER CHAMBER
DRIP CHAMBER
TUBING

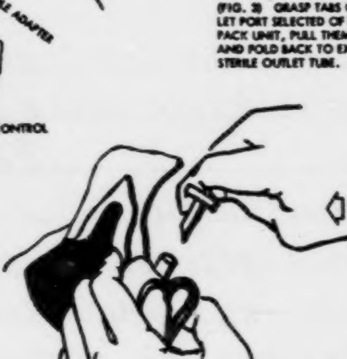
(FIG. 1) DIAGRAM OF UNIT.



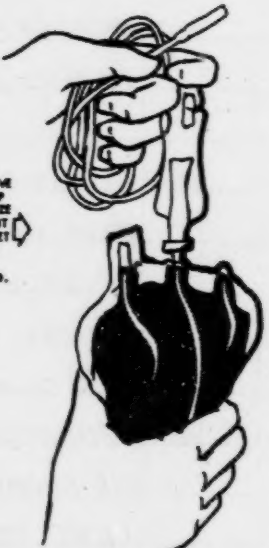
(FIG. 2) LOOSEN BUT DO NOT REMOVE COVER ON COUPLER OF SET. GRASP END OF COVER, PUSH TOWARD THE FLANGE, THEN TWIST AND LOOSEN.



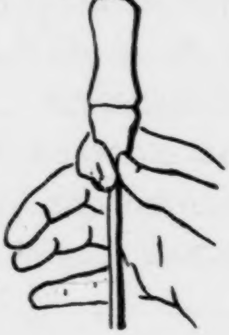
(FIG. 3) GRASP TABS OF OUTLET PORT SELECTED OF BLOOD-PACK UNIT, PULL THEM APART AND FOLD BACK TO EXPOSE STERILE OUTLET TUBE.



(FIG. 4) HOLD BLOOD-PACK UNIT WITH THUMB AND FOREFINGER OVER FOLDED TABS. REMOVE COVER FROM COUPLER OF RECIPIENT SET. INSERT COUPLER INTO THE OUTLET TUBE AND TWIST IT ALL THE WAY UP INTO THE FLANGE, PUNCTURING THE PLASTIC DIAPHRAGM OF THE PORT.



(FIG. 5) HOLD THE NEEDLE ADAPTER ABOVE THE LEVEL OF THE DRIP CHAMBER AND SQUEEZE THE BLOOD-PACK UNIT WITH THE RECIPIENT SET POINTED UPWARD TO FILL THE FILTER CHAMBER WITH BLOOD.



(FIG. 6) SQUEEZE AND RELEASE DRIP CHAMBER GENTLY UNTIL APPROXIMATELY 1/4 FULL OF BLOOD.

J Hammond
MIT

SAMPLE CHARTING

PARENTERNAL FLUIDS

Standard Form 510
Rev. Feb. 1956
Bureau of the Budget
Circular A—32
Stock No. 1-0109-201-2304

CLINICAL RECORD

NURSING NOTES
(Sign all notes)

DATE 1973	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2 MAY	1000		1000 cc 5% D/W c̄ 5 cc. MVI (I.V.) STARTED BY
			DR. MILLER. RATE REGULATED AT 64 gtt./MIN.
			RUNNING WELL.
	1100		150 cc 5% D/W c̄ MVI ABSORBED. 1000 cc 5%
			RINGER'S LACTATE ADDED TO I.V. NPO.
			Anna Jones LT, NC, USN
		1330	I.V INFILTRATED 450 cc 5% RINGER'S LACTATE
			ABSORBED. ATTEMPTS TO RESTART I.V. UNSUCSESSFUL.
			REMAINS NPO. ORAL HYGIENE GIVEN.
		1400	HYPODERMOCLYSIS 1000 cc 5% D/W STARTED IN
			THIGHS BY DR. ALBERT. RATE REGULATED AT 20 gtt/min.
			Arnold Holt HN, USN
		1850	CLYSIS TUBING CLAMPED ON RIGHT THIGH DUE TO
			PAIN AND BLANCHING AT INJECTION SITE. FLOW RATE
			OF SOLUTION CUT TO 10 gtt/MIN ORAL HYGIENE
			GIVEN. POSITION CHANGED.
		1900	500 cc. WHOLE BLOOD STARTED BY DR. ALBERT.
		2210	TRANSFUSION DISCONTINUED. ALL BLOOD ABSORBED
			NO APPARENT REACTION. CLYSIS INFUSING WELL IN
			LEFT THIGH.
		2230	EVENING CARE GIVEN. Edwin Hayes HM3, USN

Continue on reverse side

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

NURSING NOTES
Standard Form 510
510-107
PLATE NO. 10814 (REV.)

USE ADDRESSOGRAPH PLATE

ASSISTING WITH ADMINISTRATION OF MUSTARGEN

PURPOSE

To provide a chemical agent that is destructive to malignant cells.

EQUIPMENT

All equipment for I.V. Infusion
1000 cc 5% Dextrose in water
1 - 20 cc vial Mustargen
1 - 10 cc syringe
1 - 10 cc ampule of distilled water for injection
1 Sterile 21 gauge needle
Curved Basin
2 waxed paper bags and string
1 disposable drainage pad
Sterile gloves

PROCEDURE

1. Explain procedure to patient.
2. Wash hands.
3. Bring equipment to bedside.
4. Set up 1000 cc 5% Dextrose in water for intravenous infusion, in usual manner.
5. Place disposable drainage pad between the I.V. tubing and the patient's skin.
6. Infusion is started by medical officer.
7. Prepararation of Mustargen.
    a. Medical officer puts on gloves and opens ampule of Mustargen.
    b. Assistant opens sterile ampule of water in usual manner.
    c. Medical officer mixes Mustargen with water and injects directly into I.V. tubing.
8. Paper bag is held by assistant, and medical officer discards Mustargen vial, water ampule, used alcohol sponge and gloves directly into bag. Tie bag tightly and deposit in trash can. Syringe and needle tips are broken off before discarding and disposed of according to local instruction.

ASSISTING WITH ADMINISTRATION OF MUSTARGEN (Continued)

PROCEDURE (Continued)

9. Regulate infusion flow at rate ordered by the medical officer.
10. Watch patient for signs of nausea, vomiting, or infiltration of fluid into tissues.
11. Discontinue infusion in usual manner when all fluid has been taken.
12. Discard I.V. tubing, solution bottle, and used alcohol sponges into the second paper bag. Tie this bag tightly. Deposit in trash can. Syringe and needle tips are broken off while wearing protective gloves and disposed of according to local hospital instruction.
13. Wash hands thoroughly.
14. Chart time, medication and amount administered, by whom, and effect on patient.

POINTS TO EMPHASIZE

1. Medical officer will prepare and administer Mustargen.
2. Mustargen is a powerful vesicant and is highly toxic. Avoid contact with the skin or mucous membrane, especially eyes.
3. Upon completion of the infusion discard all equipment that has come in contact with the Mustargen.
4. The same procedure is used while handling other topic chemotherapeutic drugs. Use of protective gloves while preparing agents such as Vincristine and 5-Fluorouracil is essential.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

HOT WATER BOTTLE

PURPOSE

To provide external heat to the body.
To provide hyperemia and relieve congestion.
To hasten suppuration.

EQUIPMENT

Bath thermometer
Hot water bottle and cover
Hot water
Pitcher

PROCEDURE

1. Fill bottle with hot water to warm it.
2. Fill pitcher with water that does not exceed 125° F temperature as tested with a thermometer.
3. Fill bottle one-third to one-half full.
4. Place on flat surface to expel air. Secure top and check for leaks.
5. Wipe dry and cover.
6. Apply to the affected area.
7. Refill as necessary to maintain adequate heat.

POINTS TO EMPHASIZE

1. Check patient's skin frequently for redness.
2. Be sure hot water bottle is covered before placing on affected area.
3. Temperature of water should not exceed 125° F unless otherwise ordered.
4. When bath therometer is not available test water temperature on inside of your wrist.

CARE OF EQUIPMENT

Drain, wash with soap and water, rinse and hang to dry.

ADDITIONAL INFROMATION FOR THIS ACTIVITY

HOT WET COMPRESSES (CLEAN)

PURPOSE

To relieve pain, congestion, and inflammation.
To improve circulation to a body part.

EQUIPMENT

Hot plate
Basin of warm solution as ordered
Compresses
Protective sheet or pads

PROCEDURE

1. Wash hands.
2. Tell patient what you are going to do.
3. Place compresses in basin of solution on hot plate.
4. Turn on hot plate to "Low" and heat solution until desired temperature has been reached. (105° F unless otherwise ordered).
5. Place protective sheet or pads in position.
6. Use forceps to remove compresses from solution if hands are sensitive to heat or temperature ordered is higher than 105°.
7. Wring compress as dry as possible. Shake out and place on area to be treated.
8. Replace as necessary to maintain continuous heat.
9. Record time, duration and effect of treatment.

POINTS TO EMPHASIZE

1. Keep hot plate on "low" after once heating.
2. Observe skin frequently for redness.
3. Check level of solution in basin frequently and add solution as needed.

CARE OF EQUIPMENT

1. Wash basin with soap and water.
2. Rinse and dry.
3. Return to CSR when procedure is discontinued.

HOT WET COMPRESSES (CLEAN) (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

HOT WET COMPRESSES (STERILE)

PURPOSE

To provide moist heat to an open wound, or easily infected area.

EQUIPMENT

Hot plate
Sterile basin of solution as ordered
Sterile compresses
Sterile gloves or two sterile forceps
Curved basin
Protective sheet or pads

PROCEDURE

1. Wash hands.
2. Tell patient what you are going to do.
3. Place basin of solution on hot plate.
4. Turn on hot plate to "Low" and heat solution until desired temperature has been reached. (105° F unless otherwise ordered).
5. Place protective sheet or pads in position.
6. Place sterile compresses in basin of solution.
7. Wring compress as dry as possible using sterile gloves or forceps. Shake out "live" steam. Place on area to be treated.
8. Discard used compress into curved basin. Continue to apply sterile compresses for the prescribed time.
9. Record time, solution used, duration, and effect of treatment.

POINTS TO EMPHASIZE

1. Keep hot plate on "low".
2. Observe skin frequently for redness.
3. If compresses are being applied to the eyes, a separate setup for each eye MUST be used.
4. Used compresses must be discarded and never placed into sterile solution for reuse.

CARE OF EQUIPMENT

1. Wash equipment with soap and water. Rinse and dry.
2. Return to CSR.

HOT WET COMPRESSES (STERILE) (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SOAKS, EXTREMITIES

PURPOSE

To apply moist heat or cold to an extremity.

EQUIPMENT

Foot tub/arm bath
Protective sheet and cover
Bath towel
Solution as ordered

PROCEDURE

1. Wash hands.
2. Explain procedure to patient.
3. Place protective sheet and cover under part to be treated.
4. Bring the tub of solution to the bedside and place on the protective sheet.
5. Immerse area to be treated in tub of solution.
6. Cover top of tub to retain heat.
7. Continue treatment for prescribed time.
8. At completion of treatment, remove extremity. Dry gently with towel.
9. Record time, solution used, duration, and effect of treatment.

POINTS TO EMPHASIZE

1. If hot solution is ordered, check the temperature (105° F) before starting treatment.
2. Check skin frequently for signs of reddening or blanching.
3. To prevent burning the patient, remove extremity before adding hot water.
4. Thoroughly dry areas between toes and fingers.

CARE OF EQUIPMENT

Wash equipment with soap and water. Rinse and dry.

SOAKS, EXTREMITIES (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SITZ BATH

PURPOSE

To provide moist heat to the pelvic or rectal region.

EQUIPMENT

Sitz tub or bathtub
Bath towel

PROCEDURE

1. Tell the patient what you are going to do.
2. Ascertain that room temperature of bathroom is comfortable.
3. Run water into tub (half filled). Temperature should be approximately 100° F.
4. Assist patient into tub.
5. Add more water if necessary. Pajama top should remain on patient or a bath towel used around patient's shoulders.
6. Gradually increase water temperature until patient's tolerance is reached but not beyond 120° F.
7. Continue treatment for 20 minutes. Maintain desired temperature.
8. Assist patient out of tub and into bed.
9. Apply dressing if necessary.
10. Record time, duration and effect of treatment.

POINTS TO EMPHASIZE

1. Maintain tolerated water temperature throughout treatment. DO NOT raise the temperature of water above 120° F.
2. When adding more water, protect patient from the direct stream of hot water. Keep hand between patient and stream of water.
3. Watch patient for signs of dizziness, faintness and exhaustion.
4. Avoid chilling.
5. If surgical wound is present, apply fresh dressing.
6. If bath tub is used, instruct patient to sit with knees flexed and feet on the floor of tub.

SITZ BATH (Continued)

CARE OF EQUIPMENT

Clean tub with scouring powder. and disinfectant.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SAMPLE CHARTING

HEAT AND COLD TREATMENTS

Standard Form 510
Rev. Feb. 1956
Bureau of the Budget
Circular A—32
Stock No. 1-0109-201-2304

CLINICAL RECORD | **NURSING NOTES** (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1973			HEAT TREATMENTS
2 MAY	0900		HOT STERILE COMPRESSES TO RIGHT EYE FOR 20 MINUTES.
			EYE INFLAMED. SMALL AMOUNT OF YELLOW DISCHARGE
			NOTED. COMPLAINS OF "BURNING" UPON BLINKING.
			John Bauer HN, USN
	1000		SITZ BATH FOR 20 MINUTES. STATES, "I FEEL MUCH
			BETTER." PILONIDAL SINUS LESS REDDENED.
	1130		HOT WATER BOTTLE TO FEET. Jane Rowe ENS, NC, USNR
		1300	HOT STERILE COMPRESSES TO RIGHT EYE FOR 20
			MINUTES. EYE LESS INFLAMED. FEELS "MUCH LESS
			ITCHY." John Bauer HN, USN
			COLD TREATMENTS
		1900	ICE BAG TO LEFT CHEEK. SOME RELIEF OBTAINED.
			CHEEK SWOLLEN AND TENDER TO TOUCH. NO DRAINAGE
			NOTED. ABLE TO CHEW SOFT POTATOES.
		1930	ALCOHOL SPONGE BATH FOR T-103^{6}
		2015	T-101 FEELS MORE COMFORTABLE. TAKING FLUIDS WELL.
		2100	H.S. CARE GIVEN. COMPLAINS OF BURNING SENSATION
			WHEN HE URINATES. DR. FOLEY NOTIFIED.
		2200	T-100^{2} SEEN BY DR. FOLEY. URINE SPECIMEN FOR
			C&S OBTAINED AND SENT TO LAB.

Continue on reverse side

Joseph Jones HM3 USN

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

REGISTER NO. | WARD NO.

NURSING NOTES
Standard Form 510
510-107

PLATE NO. 10014 (REV.)

USE ADDRESSOGRAPH PLATE

TREATMENT PAD, HOT-COLD, CIRCULATING

(Aquamatic. K-Pak)

PURPOSE

To provide a controlled temperature in the application of heat or cold.

EQUIPMENT

Pad with control unit
Distilled water
Elastic band and safety pin
For moist heat or cold add:
  Compresses
  Basin of solution
  Basin cracked/crushed ice

PROCEDURE

1. Explain procedure to patient.
2. Connect pad tubing to two outlets at back of control unit. (Hold tubing from turning and screw knurled sleeves of pad tube fittings to control unit fittings) page 164.
3. Unscrew reservoir cap and fill unit with distilled water - at least two-thirds full.
4. Tilt control unit slowly from side to side and end to end to allow air bubbles to escape.
5. Place 3-prong safety plug in grounded wall outlet. Turn on switch. To fill pad with water, slide switch to the right on "ON" position and allow to run for a minimum of two minutes.
6. Switch unit off and tilt control unit again to allow air bubbles to escape.
7. Refill reservoir to cap level. Replace cap but loosen one fourth turn.
8. To set desired temperature, insert setting key through slit in black rubber grommet in center of dial. Be sure that key is seated in socket underneath grommet and turn key until indicator points to desired temperature on dial. Key is kept secured according to hospital policy.

TREATMENT PAD, HOT-COLD, CIRCULATING (Continued)

(Aqumatic. K-Pak)

PROCEDURE (Continued)

9. Temperature setting should be determined by the doctor.
    Dry heat--Usually 115 degrees F.
    Moist heat--Usually 105 degrees F.
    Cold--"Cool" for room temperature. For colder temperatures coil as much of tubing as possible in basin of ice.
10. Place pad over or under affected area. Pad may be placed to conform to any body contour.
11. Loop elastic band over excess tubing and pin to bed. Allow sufficient tubing to permit patient to move freely in bed.
12. Keep control unit level with or above pad level.
13. If moist heat is ordered, a moist compress is applied to the affected area and the K-pak is applied as usual around the compress.
14. When treatment is discontinued:
    a. Turn off switches.
    b. Disconnect wall plug.
    c. Disconnect tubing from control unit.
    d. Allow water to drain from tubing.
15. Record time, duration and effect of treatment.

POINTS TO EMPHASIZE

1. Use distilled water ONLY in reservoir cap. Always maintain visible water supply.
2. If oxygen is being used, keep unit at least 3 feet away from oxygen equipment or oxygen tent.
3. Be certain that tubing and pad are not kinked.
4. Check condition of patient's skin every 6 hours.
5. Moisten compresses as needed when used.
6. Do not use pins to fasten pads in place.

TREATMENT PAD, HOT-COLD, CIRCULATING (Continued)

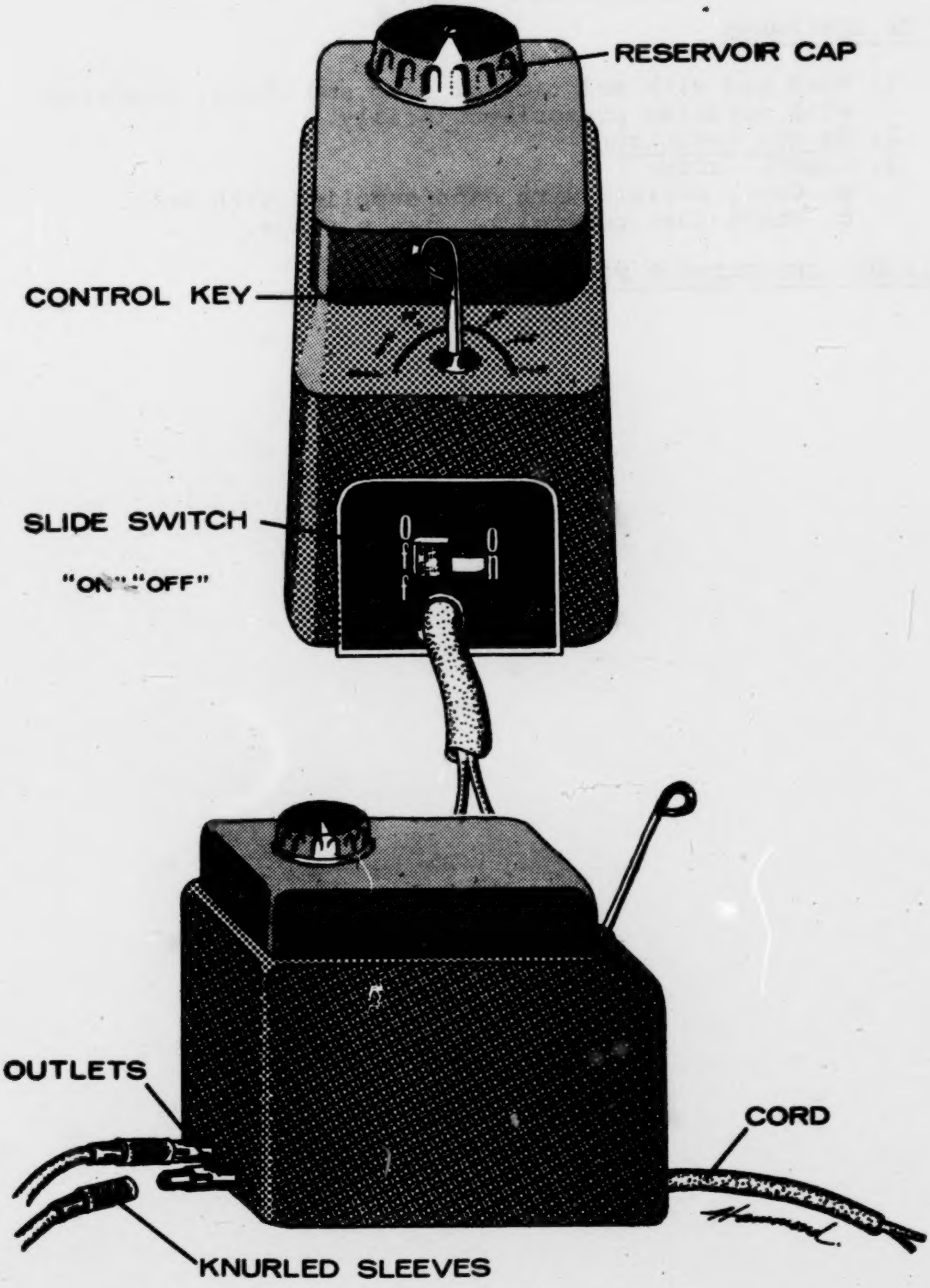
(Aquamatic. K-Pak)

CARE OF EQUIPMENT

1. Wash pad with solution of soap and water. Disinfect with solution prescribed locally.
2. Do not autoclave.
3. Control unit:
   a. Cover outlets with caps supplied with unit.
   b. Check that control key is in place.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

K-PAK


RESERVOIR CAP
CONTROL KEY
SLIDE SWITCH
"ON"-"OFF"
Off
On
OUTLETS
CORD
KNURLED SLEEVES
Hammond

HEATER, HEAT TREATMENT PAD
HYDROCOLLATOR

PURPOSE

To provide moist heat to a large area.
To relieve painful muscle spasm.

EQUIPMENT

Hydrocollator master unit with tank, wire rack and gel-filled steam packs
Three bath towels
Distilled water

PROCEDURE

1. Explain procedure and purpose to patient.
2. Fill tank three-fourths full with distilled water.
3. Immerse packs, one to each section of wire rack, with loops protruding above water level.
4. Place 3-prong safety plug into grounded wall outlet.
5. Heat water about 20 minutes.
6. Fold first bath towel into thirds, and over at center, forming six layers. Place over area to be treated.
7. Fold second bath towel in same manner.
8. Grasp steam pack by loops and lift out of tank.
9. Slip pack between the third and fourth folds of the second towel. Place on top of first folded towel, making nine layers between patient's skin and pack.
10. Cover entire area with third towel.
11. Use freshly heated pack every 30 minutes.
12. Keep pack wrapped in bath towel when transporting from tank to patient.
13. Record time, duration and effect of treatment.
14. Unplug unit from wall socket upon completion of treatment.

POINTS TO EMPHASIZE

1. Check skin frequently for redness.
2. The heated steam pack is extremely hot. Avoid burning patient by proceeding carefully until completely familiar with its heat characteristics.

HEATER, HEAT TREATMENT PAD (Continued)

(HYDROCOLLATOR)

POINTS TO EMPHASIZE (Continued)

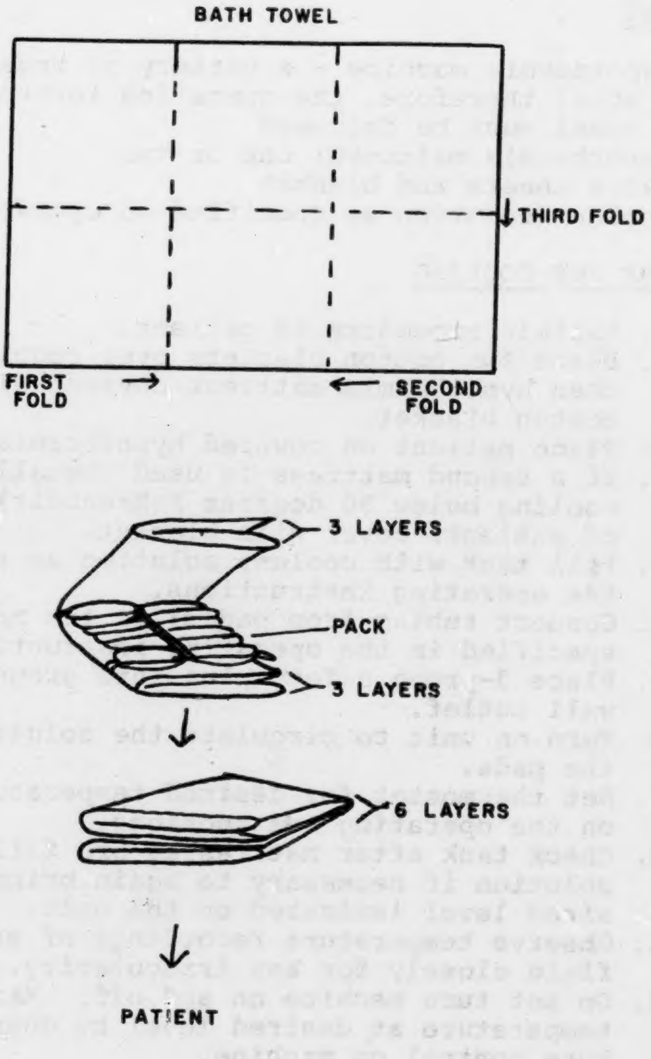
3. Intensity of heat may be decreased by adding more layers of toweling.
4. Arrange packs to fit any body contour. Roll pack along one dimension, or hinge into a "V" along other dimensions.
5. Use two or more packs alongside each other for covering large areas.
6. Keep water level up around steam packs to avoid burning out heat element, or scorching packs.
7. Use only distilled water to prevent corrosion of tank.
8. The thermostat, located on the underside of tank, has been pre-set by manufacturer at 170 degrees F., and should not require adjustment.
9. Use only on clean, closed skin areas.

CARE OF EQUIPMENT

1. Always return packs to water after each treatment.
2. Scrub packs with soap and water when necessary. Constant immersion in water usually keeps packs sufficiently clean.
3. Empty and clean tank every two weeks.
4. Prepare for storage if packs will be out of use for an extended period of time.
    a. Remove packs and hang by loops to dry (2-3 days).
    b. Empty and clean tank and wire rack.
    c. Replace rack and packs.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION OF TOWEL FOR HYDROCOLLATOR PACK


BATH TOWEL
THIRD FOLD
FIRST FOLD
SECOND FOLD
3 LAYERS
PACK
3 LAYERS
6 LAYERS
PATIENT

USE OF HYPO/HYPER-THERMIA UNIT

PURPOSE

To maintain a patient's body temperature by applying controlled external heat or cold.

EQUIPMENT

Hypothermia machine - a variety of models are available; therefore, the operating instruction for each model must be followed
Hypothermia mattress; one or two
Extra sheets and blanket
Coolant solution as specified on operating instructions

PROCEDURE FOR COOLING

1. Explain procedure to patient.
2. Place two cotton blankets over regular mattress, then hypothermia mattress covered with another cotton blanket.
3. Place patient on covered hypothermia blanket.
4. If a second mattress is used (Usually for quicker cooling below 90 degrees Fahrenheit) place on top of patient; cover with blanket.
5. Fill tank with coolant solution as specified on the operating instructions.
6. Connect tubing from pad(s) to the machine as specified in the operating instructions.
7. Place 3-prong safety plug into grounded electrical wall outlet.
8. Turn on unit to circulate the solution through the pads.
9. Set thermostat for desired temperature, as specified on the operating instructions.
10. Check tank after mattresses are filled, add coolant solution if necessary to again bring fluid to desired level indicated on the unit.
11. Observe temperature recordings of patient and pad fluid closely for any irregularity.
12. Do not turn machine on and off. Maintain patient's temperature at desired level by changing temperature control on machine.

PROCEDURE FOR WARMING

1. Many units have a warming mechanism whereby resetting of the patient temperature control automatically increases the temperature of the circulating solution.
2. If unit does not have a warming mechanism, warm solution must be introduced into the system manually and circulated by pumping it through the unit.
    a. Explain procedure to patient.
    b. Turn off pump switch and heater/cooler switch.
    c. Lower drain tube into a four gallon container and drain off coolant solution.
    d. Replace drain tube.
    e. Pour three gallons of warm distilled water (approximately 130 degress Fahrenheit) into tank.
    f. Set water pressure.
    g. Turn on heater cooler switch. Red light is usually on when warming.
    h. Adjust thermostat to desired temperature.
    i. When desired temperature is attained, turn on pump switch.
    j. Use warm water for almost immediate application of warming temperature; for slower rewarming, coolant solution is used.

POINTS TO EMPHASIZE

1. Follow directions for operating that are supplied with the unit.
2. Observe precautions when gases or oxygen is used in close proximity with the unit.
3. Note any reaction and notify medical officer immediately.
4. Check temperature every 15 minutes.
5. Turn patient at least every hour.
6. Check skin condition carefully for impaired circulation. Massage reddened area with lotion.
7. Always hold end of lead tubes as high or higher than the top of the unit and also higher than the mattresses when connecting or disconnecting them.

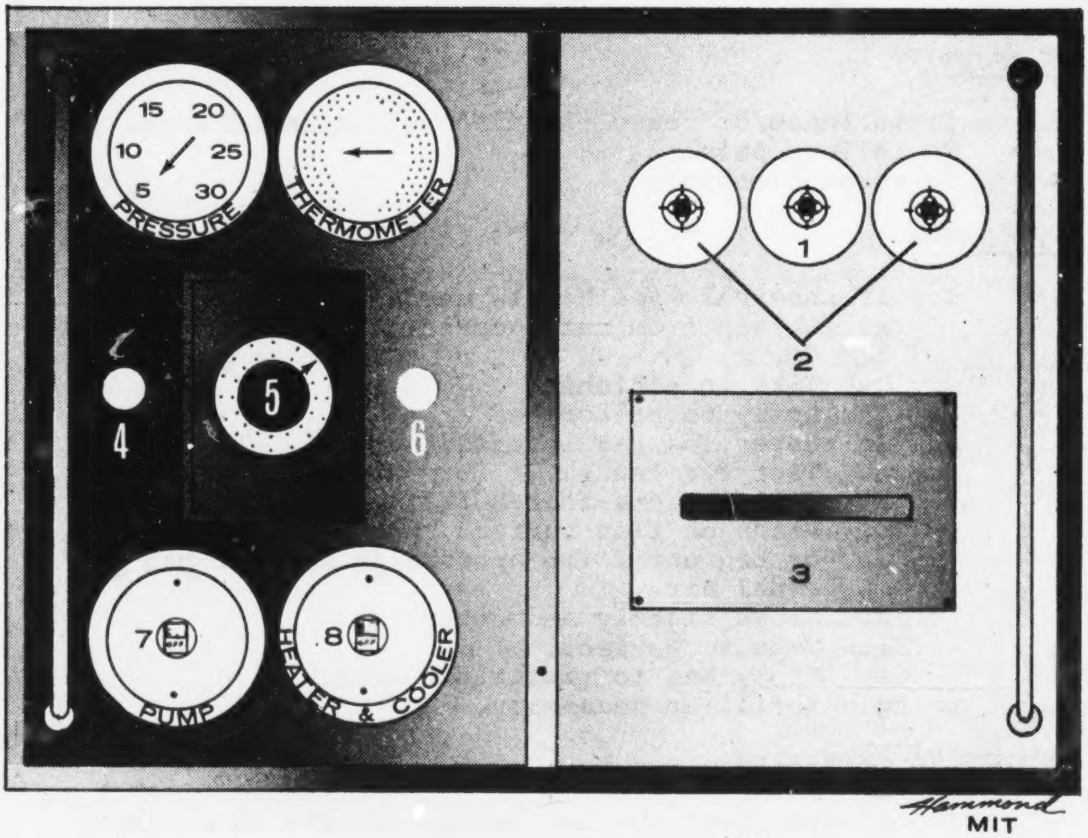
POINTS TO EMPHASIZE (Continued)

8. Do not twist or kink lead tubes of unit.
9. Do not lift weight of large blankets by the lead tubes.
10. Never fold mattresses crosswise of tubing; lay flat or roll loosely lengthwise of tubing.
11. If coolant solution shows foreign matter after prolonged use, empty and replace with fresh solution.

CARE OF EQUIPMENT

1. Wash pad with solution of soap and water. Disinfect with solution prescribed locally.
2. Do not autoclave.
3. Pads should be rolled loosely when storing.

ADDITIONAL INFORMATION FOR THIS ACTIVITY


15
20
10
25
5
30
PRESSURE
THERMOMETER
1
2
4
5
6
3
7
8
OFF
PUMP
HEATER & COOLER
Hammond
MIT

HYPOTHERMIA MACHINE

1. Pressure Valve
2. Service Valves
3. Tank Lid
4. Green Light
5. Thermostat
6. Red Light
7. Pump Switch
8. H&C Switch

ICE BAG

PURPOSE

To increase/decrease the circulation in an area.
To relieve pain.
To check bleeding.

PROCEDURE

1. If chemical type bag is used:
    a. Obtain from refrigerator.
    b. Cover.
    c. Take to patient.
    d. Apply to prescribed area.
2. If rubber ice bag is used:
    a. Test for leaks.
    b. Fill bag one-fourth full of ice.
    c. Place on flat surface, press from bottom of bag until ice appears in neck of bag to expel air.
    d. Close tightly and cover.
    e. Take to patient.
    f. Apply bag to prescribed area.
    g. Refill as necessary.

POINTS TO EMPHASIZE

1. Always cover the bag before placing on patient. Change cover when it becomes moist.
2. Check patient's skin frequently for blanching or mottling.
3. If cracked ice is not available, bag may be filled with water to which 70% alcohol is added. Place in refrigerator. (Alcohol will keep bag flexible.)
4. Rubber gloves filled with ice or ice water may be used as a substitute for rubber ice bag.

CARE OF EQUIPMENT

1. Chemical type bag:
    a. Wash and dry. Place in refrigerator.
2. Rubber ice bag:
    a. Drain and wash with soap and water.
    b. Hang to dry.

ICE BAG (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLD WET COMPRESSES (CLEAN)

PURPOSE

To relieve inflammation and reduce congestion.
To prevent or reduce swelling.

EQUIPMENT

Basin of ice water
Compresses
Protective sheet and cover

PROCEDURE

1. Tell patient what you are going to do.
2. Place compresses in basin of ice water.
3. Place protective sheet and cover in position.
4. Wring out compresses as dry as possible. Place on area to be treated.
5. Repeat step #4 every 2 minutes for 20 minutes.
6. Record time, duration, and effect of treatment.

POINTS TO EMPHASIZE

Observe skin frequently for signs of blanching or mottling.

CARE OF EQUIPMENT

Wash basin and protective sheet with soap and water.
Rinse and dry.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLD WET COMPRESSES (STERILE)

PURPOSE

To relieve inflammation and reduce swelling using aseptic technique.

EQUIPMENT

Flask of sterile water
Sterile basin
Sterile compresses
Sterile disposable gloves
Large basin of cracked ice
Curved basin
Protective sheet or pads

PROCEDURE

1. Wash hands.
2. Tell the patient what you are going to do.
3. Pour sterile water into sterile basin and place basin of sterile water into basin of cracked ice.
4. Place protective sheet or pads in position.
5. Using sterile gloves, place compresses in basin of sterile water.
6. Wring out compress as dry as possible. Place on area to be treated.
7. Repeat step #6 every 2 minutes for 20 minutes.
8. Discard used compresses.
9. Record time, duration and effect of treatment.

POINTS TO EMPHASIZE

1. Observe skin frequently for signs of blanching or mottling.
2. If compresses are being applied to both eyes, separate equipment for each eye MUST be used.
3. Used compresses must be discarded and never returned to basin.

CARE OF EQUIPMENT

1. Wash, rinse, and dry equipment.
2. Return to CSR.

COLD WET COMPRESSES (STERILE) (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SPONGE BATH

PURPOSE

To reduce body temperature.

EQUIPMENT

Basin of water 95° to 100° F or
70% Isopropyl alcohol diluted with equal parts of water (If ordered)
Seven washcloths
Bath towel
Protective sheet and cover
Thermometer

PROCEDURE

1. Tell patient what you are going to do.
2. Prepare patient and his unit as for cleansing bath.
3. Place protective sheet and cover under patient.
4. Wring out cloths in cold water or solution. Place one in each axilla, groin and under each knee. Replace cloths frequently.
5. Wring out cloth. Gently pat solution over entire body except head, genitalia and abdomen, leaving body only damp enough for rapid evaporation of solution. Expose one area of body at a time. Turn patient on abdomen or side, condition permitting, to sponge back and extremities. Entire procedure should take approximately 30 minutes.
6. Watch patient for signs of chilliness, cyanosis or increased pulse rate and discontinue procedure immediately if they occur.
7. Take temperature 10 minutes after procedure is completed.
8. Remove equipment, dry patient and make bed.
9. If temperature has not been lowered to a desirable level, the medical officer may order the bath repeated.
10. Leave patient comfortable and unit neat.
11. Record time and duration of treatment, reaction if any, and T.P.R. before and after treatment.

SPONGE BATH (Continued)

POINTS TO EMPHASIZE

1. Alternate cloths so that the applied solution is as cool as possible.
2. Remember that even diluted alcohol is very irritating to mucous membranes and may cause severe burning of the eyes, genitalia and rectum.

CARE OF EQUIPMENT

Wash, rinse and dry equipment.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

INSTILLATION OF EYE OINTMENT

PURPOSE

1. To treat infection.
2. To dilate or constrict pupil of the eye.
3. To lubricate eye.

EQUIPMENT

Ophthalmic medication as ordered
Paper wipes

PROCEDURE

1. Wash hands.
2. Identify patient and explain procedure.
3. Place patient in bed or sitting in chair with head supported.
4. Read label on medication tube three times.
5. Cleanse any discharge from eyelids. Using paper wipes, cleanse any discharge present by wiping from the inner to outer corner of the eye.
6. Draw down lower lid gently by placing two fingers on bony prominence of the orbital cavity.
7. Ask patient to look up.
8. Apply ointment along rim of lower lid.
9. Ask patient to close eyes.
10. Record medication on Medication Administration Record (MAR).
11. Record any unusual reaction or discharge on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Check label on tube for name of drug, concentration, and date of expiration. Be sure it is an opthalmic preparation.
2. DO NOT permit the tip of the tube to touch the eye.
3. A separate tube should be used for each patient.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

INSTALLATION OF EYE DROPS

PURPOSE

To provide solution into the orbital cavity in order to:

Dilate or constrict the pupil of the eye.
Relieve inflammation or treat certain eye conditions.

EQUIPMENT

Opthalmic solution as ordered
Paper wipes

PROCEDURE

1. Wash hands.
2. Identify patient and explain procedure.
3. Place patient in bed or sitting in a chair with head supported.
4. Read label on medication bottle 3 times.
5. Draw medication into dropper.
6. Take a paper wipe and gently draw lower lid down by placing fingers on bony prominence of the orbital cavity.
7. Ask patient to look up.
8. Instill prescribed number of drops into pocket formed by lower lid.
9. Have patient close eyes. Hold wipe at inner corner of eye.
10. Record medication on Medication Administration Record.
11. Record any unusual reaction or discharge on the Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. A MISTAKE MAY CAUSE BLINDNESS. Check label on medicine bottle for name of drug, concentration, date of preparation and expiration. Be sure it is an opthalmic preparation.
2. Do Not permit the dropper to touch the eye.
3. Do Not drop medication directly on the cornea.
4. Each patient should have his own prescribed medication and dropper.

INSTILLATION OF EAR DROPS

PURPOSE

To soften wax.
To relieve pain.
To shrink foreign body.

EQUIPMENT

Prescribed medication with dropper.

PROCEDURE

1. Wash hands.
2. Identify patient and explain procedure.
3. Turn patient on side.
4. Read label on medication bottle three times.
5. Draw medication into dropper.
6. Straighten ear canal:
   a. Adult - draw lobe up, back, and out.
   b. Child - draw lobe down and back.
7. Instill prescribed number of drops into ear.
8. Ask patient to remain in position for a few minutes.
9. Record medication instilled on Medication Administration Record.
10. Record any unusual reaction or discharge on the Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Do Not permit dropper to touch ear.
2. Discard any medication remaining in the dropper.
3. Each patient should have his own prescribed medication and dropper.
4. Do not insert cotton into ear unless specifically ordered; if ordered place loosely in ear.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

INSTILLATION OF NOSE DROPS

PURPOSE

To provide medication or lubrication to the mucous lining of the nose.

EQUIPMENT

Prescribed medication with dropper
Paper wipes

PROCEDURE

1. Wash hands.
2. Identify patient and explain procedure.
3. Place patient in supine position with head hanging over edge of bed.
4. Read medication label three times.
5. Instill number of drops ordered in each nostril. Discard any medication left in dropper.
6. Have patient hold head in position until drops run well back into nasopharynx.
7. Record medication instilled on Medication Administration Record.
8. Record any unusual reaction or discharge on the Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Do Not permit the dropper to touch the nose.
2. Each patient should have his own medication and dropper.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

THROAT IRRIGATION

PURPOSE

To relieve inflammation of mucous membrane of pharynx.
To remove secretions from the affected area.
To apply moist heat to mucous membranes of pharynx.

EQUIPMENT

Irrigation can with 3 feet of rubber tubing or disposable bag
Clamp
Basin for return flow
Solution as ordered
Protective sheet or pads
Paper wipes
I.V. Standard
Six inch rubber tip with adapter

PROCEDURE

1. Wash hands.
2. Identify patient and explain procedure.
3. Turn patient on side or place in sitting position.
4. Place protective sheet or pad in position.
5. Place basin in front of patient.
6. Connect irrigating can tubing to adapter on 6" rubber tip and apply clamp.
7. Hang can on standard 12" above bed level.
8. Fill irrigating can with solution.
9. Open clamp and allow small amount of solution to run into basin. Then clamp off the flow.
10. Instruct patient to:
    a. Breathe through his nose.
    b. Direct flow toward painful areas.
    c. Take frequent rest periods.
    d. Avoid swallowing solution.
11. Assist patient.
12. Have patient place rubber tip in mouth.
13. Open clamp and allow solution to flow.
14. Watch patient; pinch tubing when he stops to rest.

THROAT IRRIGATION (Continued)

PROCEDURE (Continued)

15. When all solution is used, disconnect tubing from adapter and place adapter and 6" rubber tip in curved basin.
16. Remove all equipment and leave patient clean and comfortable.

POINTS TO EMPHASIZE

1. If hot solution is ordered, test solution on wrist before starting treatment to prevent burning.

CARE OF EQUIPMENT

1. Wash equipment with soap and water. Rinse and dry.
2. Send irrigating can, tubing and adapter to CSR for resterilization.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CATHETERIZATION OF THE MALE PATIENT

PURPOSE

To remove urine from the bladder in order to collect sterile urine specimen.
Aid in decompression of the bladder.

EQUIPMENT

Sterile catheterization tray (disposable if available)
Sterile gloves
Water soluble lubricant
Cleansing or disinfectant solution
Protective sheet or pad
1 unsterile curved basin

PROCEDURE

1. Wash hands.
2. Assemble equipment and take to patient's bedside.
3. At bedside:
   a. Screen patient and tell him what your are going to do.
   b. Place patient in dorsal recumbent position.
   c. Fan fold top bedding to patient's knees. Place protective sheet or pad under buttocks. Cover his chest with extra sheet if necessary.
   d. Open sterile tray on bedside locker.
      (1) Pour cleansing solution over cotton balls in container.
   e. Put on sterile gloves and arrange sterile contents of tray for easy access.
      (1) Open lubricant packet.
      (2) Gloved hand used to grasp penis while cleansing is contaminated and should not come in contact with sterile catheter, cleansed meatus, or sterile tray.

CATHERIZATION OF THE MALE PATIENT (Continued)

PROCEDURE (Continued)

3. f. Cleanse penis with moistened cotton balls, cleansing meatus repeatedly until all cotton balls have been used.
   g. Remove sterile towel from tray with sterile gloved hand. Open to one-half fold and place between patient's legs.
   h. Place sterile specimen bottle or urine container on the sterile towel.
   i. Place penis on a sterile towel.
   j. Remove sterile catheter from tray, lubricate the tip in lubricating jelly and prepare to insert catheter.
      (1) Hold penis in upright position over the pubis, using contaminated gloved hand.
      (2) Gently introduce catheter into the meatus until resistance is felt. Apply steady, gentle pressure. Lower penis and continue insertion of catheter until urine begins to flow.
   k. Allow a few drops of urine to flow through catheter, then place end of catheter into sterile specimen bottle. Collect overflow of urine in curved basin, unless entire specimen is to be sterile, in which case a sterile curved basin is obtained beforehand.
   l. Pinch catheter when urine ceases to flow and remove gently and quickly.
   m. Remove gloves and equipment from bed.
   n. Leave patient dry, covered and comfortable.
4. Measure amount of urine obtained.
5. Record hour, treatment, amount and appearance of urine obtained.
6. Record amount on Intake and Output sheet.

CATHETERIZATION OF THE MALE PATIENT (Continued)

POINTS TO EMPHASIZE

1. If a specimen is to be obtained, collect about 120 cc. directly into the specimen bottle.
2. Complete procedure must be performed using aseptic technique.
3. Do not use force inserting catheter. If undue resistance is felt, discontinue procedure.

CARE OF EQUIPMENT

1. Wash, rinse and dry reusable equipment and return to CSR.
2. Dispose of all disposable equipment.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CATHETERIZATION OF THE FEMALE PATIENT

PURPOSE

To remove urine from the bladder in order to collect sterile urine specimen and aid in decompression of the bladder.

EQUIPMENT

Sterile catheterization tray (disposable if available)
Sterile gloves
Cleansing solution prescribed locally
Water soluble lubricant
Sheet for drape
Protective sheet or pad
Unsterile curved basin

PROCEDURE

1. Wash hands.
2. Assemble equipment and take to patient's bedside.
3. At bedside:
   - a. Screen patient. Tell her what you are going to do.
   - b. Place patient in a dorsal recumbent position.
   - c. Fanfold top bedding to foot of bed. Drape patient with a sheet. Place protective sheet or pad under buttocks.
   - d. Place tray on bed between patient's legs.
   - e. Open tray. Pour cleansing solution over cotton balls in container.
   - f. Put on sterile gloves
     - (1) Arrange sterile contents of tray for easy access.
     - (2) Open lubricant packet.
   - g. Separate the vulva with the thumb and forefinger of left hand. Expose the meatus.
   - h. Cleanse meatus with moistened cotton balls. Using one cotton ball at a time, with downward stroke only, cleanse far side, near side, and center. Discard cotton ball after each stroke.
   - i. Keeping left hand in place, lubricate tip of catheter using right hand, and gently insert catheter into meatus until urine begins to flow.
   - j. Place end of catheter in sterile specimen bottle, if specimen is to be collected. Collect remaining urine in curved basin.
   - k. Pinch catheter when urine ceases to flow and remove gently and quickly.

CATHETERIZATION OF THE FEMALE PATIENT (Continued)

PROCEDURE (Continued)

3.
    l. Remove gloves and equipment.
    m. Leave patient dry, covered and comfortable.
4. Measure amount of urine obtained.
5. Record hour, treatment, amount and appearance of urine obtained.
6. Record amount on Intake and Output sheet.

POINTS TO EMPHASIZE

1. If specimen is to be obtained, collect about 120 cc. directly into the specimen bottle.
2. Complete procedure must be performed using aseptic technique
3. Do not use force inserting catheter. If undue resistance is felt, discontinue procedure.

CARE OF EQUIPMENT

1. Wash, rinse and dry reusable equipment and return to CSR.
2. Discard all disposable equipment.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

INDWELLING CATHETER
FOLEY

PURPOSE

To provide constant drainage of urine from the bladder.

EQUIPMENT

Sterile Catheterization Tray (Disposable if available)
Sterile gloves
Cleansing solution prescribed locally
Water soluble lubricant
2 sterile Foley catheters, #16 and #18 (disposable if available)
Sterile 10 cc. syringe and 26 gauge needle
Sterile water
Sterile disposable drainage bag and tubing
Adhesive tape
Safety pin/rubber band

PROCEDURE

1. Wash hands.
2. Tell patient what you are going to do.
3. Follow procedure for catheterization, using Foley catheter.
    a. Before inserting catheter test the balloon on catheter for leakage.
4. Leave catheter in place.
5. Inject correct amount of sterile water or air with syringe through lumen leading to balloon.
6. Close lumen by tying off tightly with heavy cotton or silk.
    a. This is not necessary if disposable catheters are used.
7. Attach catheter to tubing with plastic connection leading to disposable closed drainage bag.
8. Secure catheter with adhesive tape to upper thigh or abdomen according to local policy.
9. Attach disposable closed drainage bag to bed frame on side nearest the bedside table.
10. Record time of insertion of Foley catheter on Nursing Notes (SF 510).

INDWELLING CATHETER (Continued)
FOLEY

PROCEDURE (Continued)

11. Observe urine drainage for amount, color, appearance and odor.
12. Empty, measure and record contents of drainage bottle at least every 24 hours.

POINTS TO EMPHASIZE

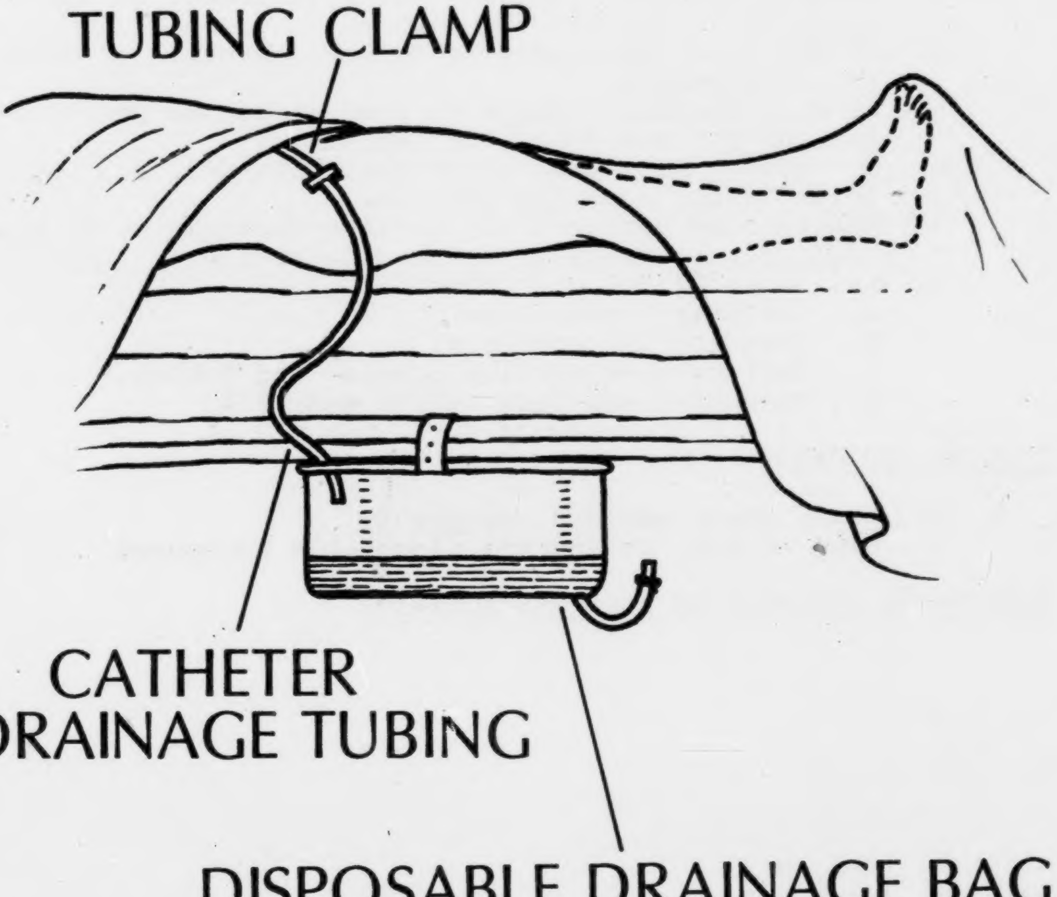
1. Always make certain that the catheter is in place in the bladder before inflating the balloon.
2. Always deflate balloon before removing the catheter.
3. Use the amount of sterile water indicated on the catheter to inflate the balloon.
4. Do not open lumen leading to balloon until catheter is to be removed.
5. Be sure drainage tubing is long enough to permit the patient to move freely in bed.
6. To prevent backflow, never allow the drainage bag to be higher than the patient.
7. Disoriented patients may require restraining to prevent urinary tract trauma and infection.
8. Follow local policies for:
   a. Catheter irrigations.
   b. Changing the catheter.
   c. Replacing collection bottles and tubing.
   d. Cleansing and care of the genitals.

CARE OF EQUIPMENT

1. Wash, rinse and dry equipment.
2. Send to CSR, or discard disposable equipment.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

GRAVITY DRAINAGE
CLOSED DRAINAGE SYSTEM


TUBING CLAMP
CATHETER DRAINAGE TUBING
DISPOSABLE DRAINAGE BAG

URINARY CATHETER IRRIGATION

PURPOSE

To cleanse an indwelling catheter of any sediment or clots by means of gentle irrigation.

EQUIPMENT

Disposable Irrigation Tray, or:
- Sterile bulb syringe
- 2 sterile curved basins
- Sterile solution
- Sterile 4 x 4's
- Antiseptic towelette

PROCEDURE

1. Wash hands.
2. Screen patient and tell him what you are going to do.
3. Have patient move to one side of bed.
4. Open sterile basins on bed along side of patient's upper thigh so as to provide a small sterile working area.
5. Follow directions on disposable irrigation package, or:
   a. Pour correct amount of sterile solution in basin #1.
   b. Disconnect drainage tubing from catheter at plastic adapter. Prevent contamination of lumen of drainage tubing by covering with sterile 4 x 4.
   c. Draw sterile solution into bulb syringe. Attach syringe to catheter. Slowly inject solution. Use amount as ordered by the physician.
   d. Remove syringe from catheter and allow solution to return into basin #2.
   e. Repeat steps c and d until all solution has been used.
   f. Use antiseptic towelette to disinfect the catheter-drainage tube connection.
   g. Connect catheter to drainage tube.
6. Remove equipment. Straighten bedclothes and leave the patient dry and comfortable.
7. Record procedure, amount and type of solution used, and if the catheter is patent on Nursing Notes (SF 510). Record on Intake and Output sheet if applicable.

POINTS TO EMPHASIZE

Do not use force when injecting solution.

CARE OF EQUIPMENT

1. Wash, dry and return to CSR.
2. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SAMPLE CHARTING

GENITOURINARY TREATMENTS

Standard Form 510
Rev. Feb. 1956
Bureau of the Budget
Circular A—32
Stock No. 1-0109-201-2304

CLINICAL RECORD | **NURSING NOTES** (*Sign all notes*)

DATE	HOUR		OBSERVATIONS Include medication and treatment when indicated
1973	A.M.	P.M.	
2 MAY	0600		CATHETERIZED. 375 cc. DARK, AMBER, CLOUDY URINE
			OBTAINED. STRONG AMMONIA ODOR PRESENT. SPECIMEN
			TO LAB. Paul Mitchell HN, USN
	0700		REGULAR DIET EATEN COMPLETELY. STATES THAT
			APPETITE IS VERY GOOD. TAKING FLUIDS WELL.
	0800		COMPLETE BED BATH GIVEN. HAIR SHAMPOOED. BACK
			AND FOOT CARE GIVEN. Gary Dawn HM3, USN
	0900		PORTABLE CHEST X-RAY DONE ON WARD.
	1000		HAS BEEN UNABLE TO VOID SINCE LAST CATHETERIZATION.
			FOLEY CATHETER (#18) INSERTED BY DR. MARSHALL.
			STRAW COLORED URINE, 500 cc. OBTAINED. CATHETER
			TO DRAINAGE BAG.
	1030		BLADDER IRRIGATION, 100 cc. STERILE SALINE.
			SOLUTION RETURNED CLEAR EXCEPT FOR FEW
			MUCOUS SHREDS.
	1110		15 cc. ZEPHIRAN CHLORIDE SOLUTION 1:3000
			INSTILLED INTO BLADDER VIA FOLEY CATHETER.
			INSTRUCTED HOW TO RECORD FLUID INTAKE.
			Richard McNamee HN, USN
	1145		COMPLAINED OF BURNING SENSATION IN PENIS.
			DR MARSHALL NOTIFIED. Gary Dawn HM3, USN

Continue on reverse side

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)	REGISTER NO.	WARD NO.
USE ADDRESSOGRAPH PLATE		

NURSING NOTES
Standard Form 510
510-107
PLATE NO. 10814 (REV.)

EXTERNAL CATHETER
DUNBAR DRAIN

PURPOSE

To prevent skin breakdown due to incontinence.

EQUIPMENT

Disposable urosheath
Tape
Urinary drainage tube and bag

PROCEDURE

1. Wash hands.
2. Tell patient what you are going to do.
3. Select size of urosheath (small, medium, large).
4. Follow directions on box.
5. Connect to closed urinary drainage bag.

POINTS TO EMPHASIZE

1. Change frequently to prevent skin maceration.
2. Apply tape loosely to prevent impairing circulation.
3. Leave adequate space between end of penis and drainage tube to prevent pressure ulcer.

CARE OF EQUIPMENT

Discard disposable items after use.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

BLADDER IRRIGATION

PURPOSE

To cleanse the bladder of any sediment or clots by means of gentle irrigation.
To insure adequate drainage of urine.

EQUIPMENT

Sterile catheterization tray (disposable if available)
Sterile gloves
Prescribed G.U. irrigant
G.U. irrigation tubing (disposable)
Three-way Foley catheter
I.V. standard
Curved basin

PROCEDURE

1. Wash hands.
2. Assemble equipment and take to patient's bedside.
3. Screen the patient and tell him what you are going to do.
4. Catheterize patient with the 3-way Foley catheter, if not already in place.
5. Connect inflow tubing to bottle of G.U. irrigant. Hang bottle on I.V. standard.
6. Run solution through tubing to clear air. Clamp inflow tubing.
7. Connect tubing to input lumen of 3-way Foley catheter.
8. Connect closed drainage tubing to output lumen of catheter and secure drainage bag to side of bed.
9. Loop rubber band around outflow tubing and pin to draw sheet.
10. To irrigate bladder:
    a. Clamp outflow tube.
    b. Release clamp on inflow tube. Allow prescribed amount of solution to flow into bladder. Clamp inflow tube.
    c. Release clamp on outflow tube. Drain the bladder.
11. Keep an accurate record of intake and output.
12. Record time, amount and type of solution used and patient's reaction on Nursing Notes (SF 510).

BLADDER IRRIGATION (Continued)

POINTS TO EMPHASIZE

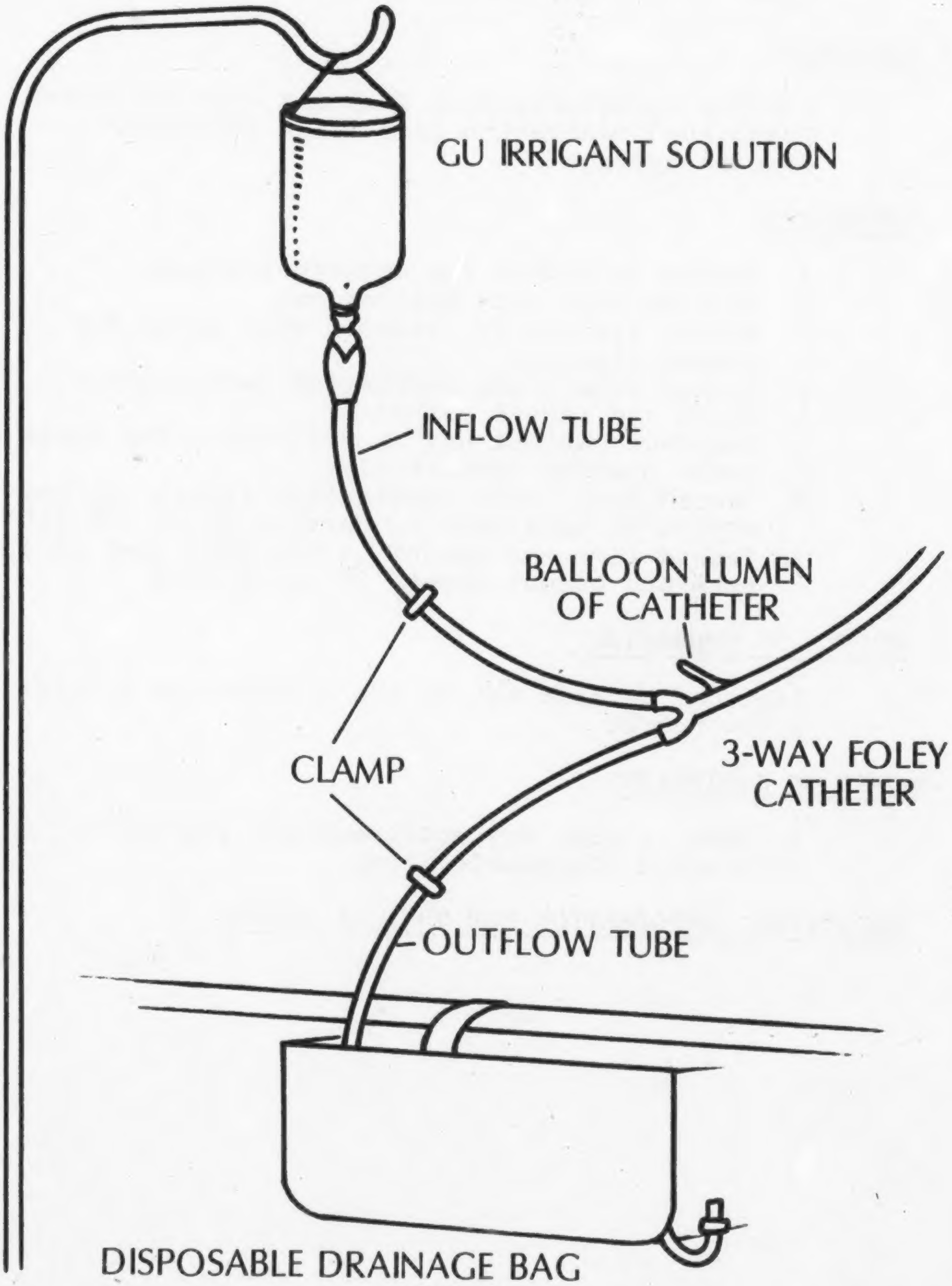
1. Regulate flow of solution into the bladder by adjusting the clamp on inflow tube.
2. Maintain sterility of equipment.

CARE OF EQUIPMENT

Discard disposable equipment after use.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

BLADDER IRRIGATION


GU IRRIGANT SOLUTION
INFLOW TUBE
BALLOON LUMEN OF CATHETER
CLAMP
3-WAY FOLEY CATHETER
OUTFLOW TUBE
DISPOSABLE DRAINAGE BAG

BLADDER INSTILLATION

PURPOSE

To instill an antiseptic solution into the bladder in order to prevent or treat infections.

EQUIPMENT

Sterile Catheterization Tray and sterile gloves
Prescribed medication in sterile container
Sterile syringe

PROCEDURE

1. Follow procedure for catheterization.
2. Fill syringe with medication.
3. Attach syringe to catheter when urine has ceased flowing.
4. Slowly inject the medication into bladder.
5. Pinch and remove catheter.
6. Instruct patient not to void for a few hours.
7. Leave patient comfortable.
8. Record date, time, medication instilled, and effect of treatment on Nursing Notes (SF 510).
9. Record time and amount of solution used on intake and output sheet, if applicable.

POINTS TO EMPHASIZE

Instruct patient not to use a bedpan or a urinal for a few hours.

CARE OF EQUIPMENT

1. Wash, rinse, dry equipment and return to C.S.R.
2. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CLEANSING ENEMA

PURPOSE

To cleanse the bowel and facilitate defecation.

EQUIPMENT

Disposable enema unit or:
Enema tray containing:
  Irrigating can with rubber tubing, plastic connecting tip and clamp
  Rectal tube, disposable if available
  Water soluble lubricant
  Toilet tissue
  Paper towels
  Protective sheet or pads
  Bedpan and cover

SOLUTIONS USUALLY ORDERED

Soap (white) solution 500-1000 cc.
Tap water 500-1000 cc.
Saline solution (1 tsp. to 1 pt.water) 500-1000 cc.
Fleet Enema disposable unit
1-2-3- enema -- 1 oz magnesium sulfate
2 oz glycerin
3 oz water

PROCEDURE

1. Instruct patient as to what you are going to do.
2. Wash hands. Assemble equipment in utility room:
    a. Attach rectal tube to connecting tip and clamp tubing.
    b. Pour solution to be used into the irrigating can:
        (1) 1/2 oz Ivory Liquid to 1000 cc. of water can be used when a soap solution is ordered.
            (a) Check temperature by pouring a small amount over inside of wrist. (Solution should be warm)
3. Carry tray and bedpan (covered) to bedside.
4. Place bedpan on chair beside bed. Place tray on bedside table.

CLEANSING ENEMA (Continued)

PROCEDURE (Continued)

5. Screen patient.
6. Lower backrest. Place protective sheet or pads under patient. Place patient in left Sims position.
7. Fold back covers to expose patient's buttocks.
8. Open clamp on tubing. Allow small amount of solution to run through tube into bedpan. Close clamp.
9. Lubricate tip of rectal tube.
10. Insert tube gently for about 4 inches into rectum. Hold in place. Open tube. Raise can approximately 18 inches above buttocks to allow solution to flow slowly.
11. If patient complains of fullness or discomfort, clamp off flow for a few minutes and position patient on his back, then to the right side. Release clamp and continue flow of solution. Instruct the patient to breathe through his mouth.
12. Continue flow until patient has taken all solution or as much as he is able.
13. Clamp and withdraw tubing. Wrap in paper towel and place on tray.
14. Place patient on bedpan. Elevate backrest if patient's condition permits.
15. Place toilet tissue and call bell within his reach.
16. Check on patient frequently until he has evacuated the solution.
17. Carry tray to utility room. Wash your hands.
18. Remove bedpan when patient is finished.
19. Take covered bedpan to utility room. Inspect contents, note amount, color and consistency. Wash your hands.
20. Take basin of water to patient to wash his hands.
21. Leave patient comfortable.
22. Record time, type of enema given, and results on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Do NOT give an enema to a patient in a sitting or standing position.
2. When a small amount of solution is ordered, urge patient to retain solution for at least 20 minutes if he is able.
3. Patient may go to the bathroom to expel enema if condition permits.

CLEANSING ENEMA (Continued)

POINTS TO EMPHASIZE (Continued)

4. When a patient uses a commode to expel enema, check contents before flushing.
5. If prepared disposable enema is used, follow directions on container.
6. NEVER use Phisohex or green soap when preparing soap solution.

CARE OF EQUIPMENT

1. Wash can and tubing with warm soapy water, rinse, dry and return to CSR.
2. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

RETENTION ENEMA

PURPOSE

To soften fecal matter and thereby facilitate defecation.
To instill medication for local or systemic effect.

EQUIPMENT

Disposable retention enema unit or enema tray with:
- Graduated measuring container
- Barrel of asepto syringe
- Rectal tube or catheter FR #20
- Curved basin
- Solution as ordered

Protective sheet or pad

PROCEDURE

1. Screen patient and tell him what your are going to do.
2. Give cleansing enema 30 minutes prior to retention enema unless contraindicated or unless oil retention enema is being given.
3. Prepare solution as ordered.
4. Attach rectal tube to asepto syringe and place in curved basin.
5. Take tray and place on bedside table.
6. Turn patient on side most comfortable for him. Fold back covers.
7. Place protective sheet and cover under patient's buttocks.
8. Lubricate rectal tube.
9. Fill syringe and tubing with solution; pinch off tubing.
10. Insert the tube about 4 inches into the rectum.
11. Raise barrel of syringe even with top of buttocks. Allow the solution to flow slowly. Keep syringe full until all solution has been given.
12. Pinch tube. Disconnect syringe. Remove tube and place in curved basin.
13. Leave patient on his side. Replace top bedclothes.
14. Instruct him to retain the solution. Allow patient to lie quietly and do not disturb him.
15. Record time, amount, type of enema given, and whether retained on Nursing Notes (SF 510) and Intake and Output sheet, if applicable.

RETENTION ENEMA (Continued)

POINTS TO EMPHASIZE

1. Solution must be given very slowly.
2. If patient has difficulty retaining solution, apply gentle pressure to anus with toilet paper until desire to defecate has passed.

CARE OF EQUIPMENT

1. Wash equipment, rinse, dry, and return to CSR.
2. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COMMONLY ORDERED ENEMAS

Type of Enema	Purpose	Proportions	Temp.	Equipment and Method	Important Points
1-2-3	Carminative to stimulate expulsion of flatus from colon.	30 cc magnesium sulfate (50%) 60 cc glycerine 90 cc water	105 F	Same as for retention enema	
Alum	Astringent, to check local bleeding in the colon.	2 oz. alum 1000 cc water.	105 F	Same as for cleansing enema.	
Tap Water	Cleansing or evacuation of feces.	500 - 1000 cc	105F	Same as for cleansing enema.	
Starch	Emollient, soothing to mucous membrane.	4 Gms corn starch, 180 cc water	105 F	Same as for cleansing enema.	Dissolve starch in cold water to make a paste. Then add boiling water to make a smooth mixture. Cool to 105 F.

COMMONLY ORDERED ENEMAS (Continued)

Type of Enema	Purpose	Proportions	Temp.	Equipment and Method	Important Points
Chloral Hydrate	Sedative	20 grains chloral hydrate 3 oz. boiled starch or olive oil (Amount must be ordered by doctor)	105 F	Same as oil retention	Amount of sedative must be ordered by doctor.
Sugar & Soda Bicarbonate	Carminative to stimulate expulsion of flatus from colon	4 oz. sugar 4 oz. $NaHCO_3$ 1000 cc water	105 F	Same as for cleansing	
Saline	Cleansing or evacuation of feces	1000 cc water 2 tsp. salt	105 F	Same as for cleansing enema	
Soap Suds	Cleansing or evacuation of feces.	1000 cc weak soap solution using mild soap	105 F	Same as for cleansing enema.	Solution should appear slightly milky.

COMMONLY ORDERED ENEMAS (Continued)

Type of Enema	Purpose	Proportions	Temp.	Equipment and Method	Important Points
Water and Clycerine	Carminative to stimulate expulsion of flatus from colon.	3 oz water 3 oz glycerine	105 F	Same as for cleansing enema	
Glycerine	Usually given to induce voiding	4 oz glycerine	105 F	Same as for cleansing enema	
Paraldehyde	Sedative	Amount prescribed by doctor. (Usually 2 drams). Mix prescribed amount with equal amount of ice water.	105 F	Same as for retention enema.	Amount of sedative must be ordered by doctor.

GASTROSTOMY FEEDINGS

PURPOSE

To introduce liquid food or medication into the stomach by means of a tube inserted directly into the stomach through a surgical opening in the abdominal wall.

EQUIPMENT

Feeding to be administered
Two protective towels
Asepto syringe or funnel
Curved basin
Cup of warm water
Sterile 4 x 4s
Paper wipes
Adhesive tape

PROCEDURE

1. Wash hands.
2. Measure prescribed amount of tube feeding to be administered into a small container. Warm feeding to room temperature by setting container in a basin of warm water.
3. Tell patient what you are going to do.
4. The patient remains flat in bed; place a protective towel on each side of gastrostomy tube.
5. Connect asepto syringe (without bulb) to end of gastrostomy tube.
6. Pour a small amount (20-30 cc) of warm water in asepto syringe to rinse tube. Release clamp.
7. To prevent air entering the tubing, follow water immediately with some of the feeding.
8. Feeding should always be given slowly. The rate of flow may be regulated by raising or lowering the asepto syringe.
9. At completion of feeding rinse tube with 20-30 cc of warm water.
10. Reclamp gastrostomy tube before removing asepto syringe to prevent backflow.
11. Check dressing around gastrostomy tube. Change if necessary.
12. Record time, type of feeding, and amount on Nursing Notes (SF 510) and Intake and Output Sheet.

GASTROSTOMY FEEDINGS (Continued)

POINTS TO EMPHASIZE

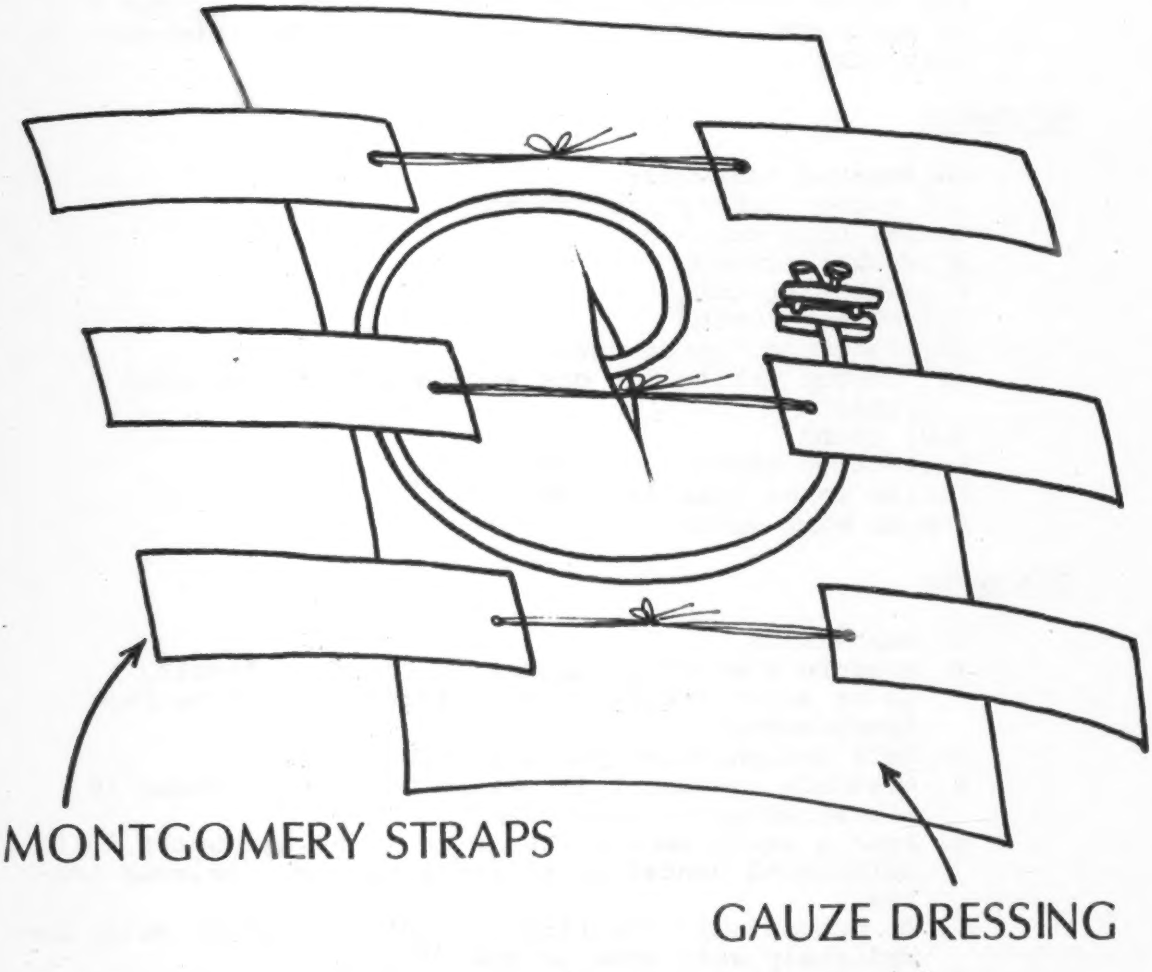
1. Do not put any tension on the gastrostomy tube during the procedure.
2. If tube is not rinsed before and after procedure it will become clogged.

CARE OF EQUIPMENT

1. After each treatment wash, rinse and dry curved basin and asepto syringe.
2. A new basin and syringe should be obtained daily.
3. After treatment is discontinued return asepto syringe to CSR.
4. If disposable items are used, discard.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

GASTROSTOMY DRESSING


MONTGOMERY STRAPS
GAUZE DRESSING

APPROXIMATELY 10 DAYS AFTER THE GASTROSTOMY PROCEDURE THE INCISION AROUND THE CATHETER IS HEALED. THE PHYSICIAN IS THEN ABLE TO REMOVE AND REPLACE THE GASTRONOMY TUBE WHEN NECESSARY FOR CLEANING PURPOSES.

MURPHY DRIP

PURPOSE

To administer fluid slowly, (drop by drop) into the gastrointestinal tract.

Note - This method is used to administer fluid into the colon (proctocylsis), stomach (gastric gavage or gastrostomy tube), or small intestine (enterostomy tube).

EQUIPMENT

Calibrated container
12" rubber tubing with clamp
Murphy Drip tube
2" rubber tubing
Y connecting tube
24" rubber tubing
Straight connecting tube
30" rubber tubing (as gas escape tube for proctocylsis)
I.V. stand
Protective sheet and cover
Fluids to be administered
Cup of warm water

PROCEDURE

1. Wash hands.
2. Measure prescribed amount of fluid or feeding to be administered into container. Warm to room temperature.
3. Tell patient what you are going to do.
4. Assemble equipment in patient's room as shown in illustration on page 213A.
5. Pour a small amount (20-30 cc.) of warm water in calibrated container to rinse tubing. Release tubing.
6. To prevent air entering the tubing, follow water immediately with some of the feeding.
7. The flask of solution is hung 12 inches above the area through which the solution is administered.
8. The flow of solution is regulated at the rate prescribed by the doctor. This may vary from 10-60 drops per minute.
9. Record on Nursing Notes (SF 510), time procedure started, type of solution, rate of flow, and any adverse effect on patient. Record amount on Intake and Output Sheet.

MURPHY DRIP (Continued)

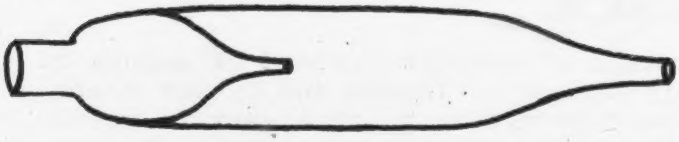
POINTS TO EMPHASIZE

1. Maintain an accurate record of amount of solution administered on Intake and Output Sheet.
2. Close observation is necessary to assure the solution is flowing at the proper rate.
3. Stoppage may result from clogged tube or inability of the patient to absorb the solution. Open clogged tube by pinching it several times. If unable to open tube, notify WMO.
4. Remember to change the patient's position frequently since this treatment may last several days.

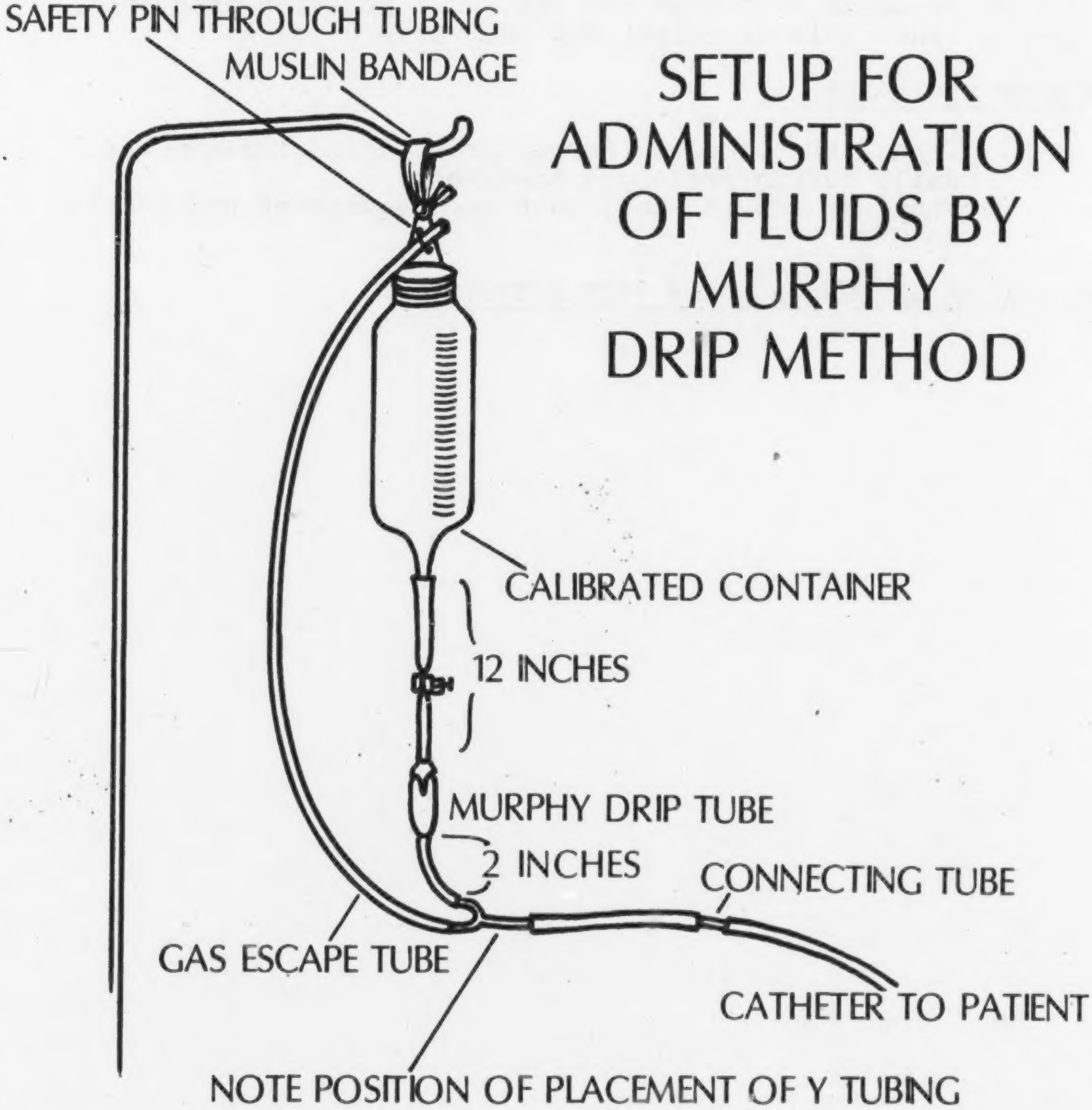
CARE OF EQUIPMENT

1. Change the complete Murphy Drip administration set daily during prolonged treatment.
2. When new set is hung, wash used equipment and return to CSR.

ADDITIONAL INFORMATION FOR THIS ACTIVITY



MURPHY DRIP TUBE



SETUP FOR ADMINISTRATION OF FLUIDS BY MURPHY DRIP METHOD

SAFETY PIN THROUGH TUBING
MUSLIN BANDAGE
CALIBRATED CONTAINER
12 INCHES
MURPHY DRIP TUBE
2 INCHES
CONNECTING TUBE
GAS ESCAPE TUBE
CATHETER TO PATIENT
NOTE POSITION OF PLACEMENT OF Y TUBING

GASTRIC LAVAGE

PURPOSE

To wash out the stomach.

EQUIPMENT

Stomach tube (Ewald) in basin of ice or plastic stomach tube with removable funnel
Large pitcher of solution as ordered
Large pail
Protective sheet or pads
Curved basin
Paper wipes
Water soluble lubricant
Stethoscope

PROCEDURE

1. Wash hands.
2. Tell patient what you are going to do.
3. Place protective sheet and cover in position.
4. Place pail in position to receive return flow.
5. Lubricate tube.
6. Place tube far back in mouth. Ask patient to swallow. Each time patient swallows insert tube a few inches until marker is reached.
7. Tube should pass without coughing, change in color or disturbance in respiration. If in doubt, remove tube. (A stomach tube with a removable funnel may be injected with air. A stethoscope in place on the epigastric area of the abdomen will detect the sound of air rushing into the stomach.
8. When tube has been inserted into the stomach, pour approximately 350 cc. of solution through funnel into stomach.
9. Invert funnel over pail and below level of patient's stomach, allowing contents of the stomach to flow out.
10. When flow of stomach contents ceases; raise funnel above level of patient's stomach and pour in about 350 cc. of solution.
11. Repeat steps 8 and 9 until all solution has been used and return flow has ceased.
12. Pinch tubing at patient's lips. Remove quickly.
13. Record time, amount of solution used, and amount and character of returns on Nursing Notes (SF 510).

GASTRIC LAVAGE (Continued)

POINTS TO EMPHASIZE

Tube should be firmly pinched off while being removed to prevent aspiration of gastric contents into lungs.

CARE OF EQUIPMENT

1. Wash, rinse, dry and return to CSR.
2. Discard disposable items

ADDITIONAL INFORMATION FOR THIS ACTIVITY

GASTRIC GAVAGE

PURPOSE

To introduce liquid food or medication into the stomach by means of a tube.

EQUIPMENT

Levin tube, rubber or plastic
Water soluble lubricant
20 or 30 cc. syringe
Asepto syringe (without bulb) or plastic calibrated container with attached tubing, clamp and connector.
Protective sheet or pad
Paper wipes
Curved basin
Adhesive tape
Clamp
Container of prescribed fluid
I.V. Standard
Stethoscope
Cup of warm water

PROCEDURE

1. Wash hands.
2. Measure prescribed amount of solution in container. Warm feeding to 105° F by setting container of feeding in basin of warm water.
3. Tell patient what you are going to do.
4. Place patient in semi-Fowler's position if not contraindicated.
5. Place protective sheet or pad in position.
6. Lubricate end of tube to be inserted.
7. Hold tube six inches from tip.
   Insert through nose until second marker has been passed.
8. Tube should pass without coughing, change in color or disturbance in respiration. When certain that tube is not in trachea, attach syringe and aspirate for gastric contents or inject tube with a syringe full of air. A stethoscope in place over the epigastric area of the abdomen will detect the sound of air rushing into the stomach.
9. Clamp tube, remove syringe and tape tube in place.

GASTRIC GAVAGE (Continued)

PROCEDURE (Continued)

10. Attach asepto syringe.
11. Pour warmed solution into asepto syringe.
12. Release clamp. Allow solution to run through tubing slowly and refill asepto syringe so as not to allow air to enter tubing.
13. Repeat steps 11 and 12 until all solution is administered.
14. Add a small amount of warm water to clear Levin tube when feeding is finished.
15. Clamp tube. Disconnect asepto syringe.
16. If disposable plastic container and tubing is used:
    a. Follow steps 1 through 9.
    b. Pour solution to be administered into plastic container after clamping off the tubing.
    c. Hang container on I.V. standard.
    d. Release clamp. Allow solution to run through tubing. Replace clamp and connect tubing to the Levin tube by means of the plastic connector.
    e. Release clamp, allowing fluid to flow at a slow steady rate.
    f. Add small amount of warm water to clear Levin tube when feeding is finished.
    g. Clamp Levin tube. Disconnect from plastic tubing and container.
17. Pinch and remove Levin tube quickly. Leave Levin tube in place and clamped if procedure is to be repeated.
18. Record time, amount and type of solution administered, and reaction of patient on Nursing Notes (SF 510).
19. Record time, amount and type of solution on Intake and Output sheet.

POINTS TO EMPHASIZE

1. Use lubricant sparingly. If used in excess, there is danger of aspiration.
2. If patient is conscious, instruct him to swallow as tube is being passed to aid its passage.
3. If patient manifests any adverse symptoms such as choking, coughing, cyanosis, remove the tube. Allow patient to rest and attempt insertion later.
4. Insert Levin tube through nose unless contraindicated. If any obstruction is noted, discontinue and notify medical officer.
5. Be certain tube has been passed into stomach and not respiratory tract.

GASTRIC GAVAGE (Continued)

CARE OF EQUIPMENT

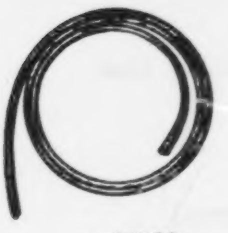
1. After each treatment, rinse plastic container and tubing with 50-100 cc water. The container and tubing should be changed daily.
2. Discard disposable items when treatment discontinued.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

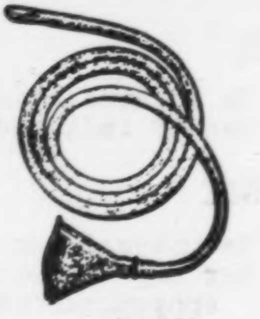
COMMONLY USED NASO GASTRIC TUBES

Type of Tube	Description	Purpose
A. LEVIN	Rubber on plastic. No. 12 - 18 Fr. 4 foot tube, multiple holes near the rounded tip.	Feeding; Gastric Decompression.
B. EWALD (Gastric Lavage)	Large lumen-passed through the mouth and into the stomach. Red rubber with bulb and single eye.	Washing out poisons or other substances from the stomach; aspirating large amounts of substances from the stomach.
C. MILLER - ABBOTT	Long double lumen tube. One lumen has an outlet into a small rubber bag. This tube has suction and inflation tips and is inflated with mercury, after intubation of tube.	Decompression of bowel by removal of air and fluid. Weighted to facilitate passage into bowel.
D. SALEM SUMP TUBE	Double lumen, rubber on plastic. Sump design permits continuous suction.	Gastric Decompression.
E. SENGSTAKEN BLAKEMORE	Rubber, triple lumen, two balloon tube. Baloons inflated following intubation.	Control of bleeding of esophageal varices by pressure from balloons.
F. CANTOR (Rubber) KASLOW (Plastic)	Single lumen, long rubber tube with a small rubber bag fastened to the distal end. Bag is filled with 5 - 10 cc of mercury.	Decompression of bowel by removal of air and fluid. Weighted to facilitate passage into bowel.

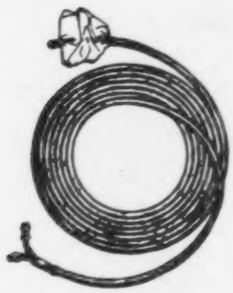
COMMONLY USED NASO-GASTRIC TUBES



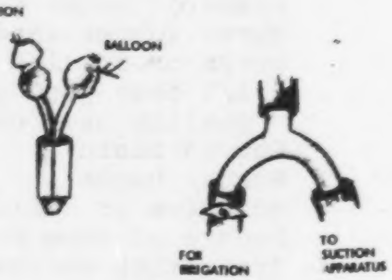
—Levin Tube.

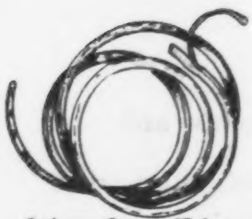


—Stomach Tube.

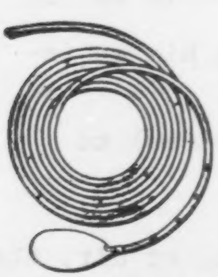


—Miller Abbott Tube.

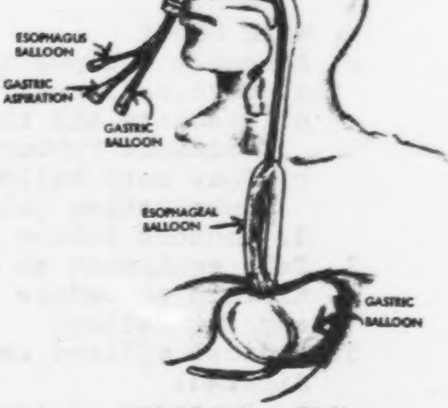

SUCTION
BALLOON
FOR IRRIGATION
TO SUCTION APPARATUS



Salem Sump Tube



—Cantor Tube.


ESOPHAGUS BALLOON
GASTRIC ASPIRATION
GASTRIC BALLOON
ESOPHAGEAL BALLOON
GASTRIC BALLOON

SengstaKen BlaKemore

ESOPHAGEAL BALLOON INTUBATION

(Sengstaken-Blakemore Tube)

PURPOSE

To control bleeding from esophageal varices by the use of inflated balloons.

EQUIPMENT

Esophageal varices tube with balloons attached
Mercury manometer or aneroid gauge of Tycos sphygmomanometer
Y connecting tube
50 cc. syringe
Constant intestinal suction machine
Water soluble lubricating jelly (not vaseline)
Glass of water with straw
Three rubber shod clamps (Crile or Kelly)
Butyn or cocaine nasal spray
2 1/2 feet good grade rubber tubing (size and quality used on blood pressure manometer)
Curved basin
Rubber bands
Adhesive or cellulose (Scotch) tape
Square of foam rubber
Irrigating solution as prescribed
Sign - "NPO" (nothing by mouth)

PROCEDURE

1. Wash hands.
2. Assemble equipment.
   a. Test balloons for air leaks.
   b. Evacuate all the air from the balloons and reinsert rubber plugs.
   c. Coat both balloons and lower part of tube with lubricating jelly.
   d. Connect tubing to Y tube and manometer tube.
3. Take equipment to patient's bedside.
4. Explain procedure to patient (prepare him as for any intubation)
5. Medical officer inserts tube. Assist him as indicated:
   a. Reassure patient.
   b. Give patient water (via drinking straw) to swallow during tube insertion.
   c. Have emesis basin ready.
6. After insertion of the tube:
   a. Inflate gastric balloon with 50 cc. of air, then clamp conical portion 3 cm from the end.

ESOPHAGEAL BALLOON INTUBATION (Continued)

PROCEDURE (Continued)

6.
   - b. Connect esophageal tube to manometer tubing.
   - c. Inflate esophageal balloon to 35-40 mm of mercury pressure.
   - d. Aspirate all air, water and blood through gastric tube.
   - e. Irrigate continuously with 50 cc. of prescribed solution to prevent clotted blood from plugging tube.
7. Connect gastric aspiration tube to suction.
8. Post "NPO" sign at bedside.
9. Follow written orders for:
   - a. Pressure checks - note base line pressure - maximum 45, not transient peaks.
   - b. Tube irrigations.
10. Keep head of bed elevated 45 to 60 degrees.
11. Record time tube inserted and by whom; pressure checks, irrigations and description of drainage, effect on and condition of patient on Nursing Notes (SF 510).
12. Keep accurate intake and output record.

POINTS TO EMPHASIZE

1. Tube is passed by Medical Officer.
2. Tension on the tube should be maintained by some form of traction. The Medical Officer will designate the method.
3. If bright red bleeding continues after 30 minutes of careful lavaging, notify doctor who may order an increase in pressure of esophageal balloon.
4. If patient continues to bleed after pressure was increased to 45 mm mercury, notify doctor (bleeding may be from gastric varices)
5. After minimal pressure (in esophageal balloon) required to control bleeding is determined, clamp tube to prevent air leaks.
6. Give medications as indicated to insure patient is adequately sedated. This helps prevent regurgitation.
7. Instruct patient to expectorate saliva as soon as it accumulates.
8. Good oral hygiene is essential.
9. Aspirate stomach for residual prior to each feeding. Gastric feedings are usually initiated after control of bleeding.
10. Wash tube with 20 cc. water after each feeding.
11. This is an emergency procedure. Tray of essential equipment should be available at all times.

ESOPHAGEAL BALLOON INTUBATION (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

INTESTINAL INTUBATION

(Miller-Abbott Tube)

PURPOSE

To decompress intestine by removing air and fluid.

EQUIPMENT

Miller-Abbott Tube
Mercury, if ordered
Water soluble lubricant
30-50 cc. syringe
Basin cracked ice
Three rubber adapters about 3" long
One small adhesive strip marked "to balloon"
One small adhesive strip marked "to suction"
Y connecting tube
One Kelly clamp
Suction-siphonage apparatus
Glass of water
Drinking tube or straw
Tissue wipes
Curved basin
Protective sheet or pads
Bath towel
Elastic bands
Safety pin
Adhesive or cellulose tape

PROCEDURE

1. Wash hands.
2. Explain procedure and its purpose to patient.
3. Attach N.P.O. sign to bed.
4. Test balloon on Miller-Abbott tube for inflation and leakage.
   a. Inflate balloon with air from syringe. Check for leaks.
   b. Immerse balloon section in water. Inflate and check for leaks by squeezing balloon.
5. Place Miller-Abbott tube in basin of cracked ice.
6. Bring all equipment to bedside and screen patient.
7. Secure bath towel around patient's neck. Place protective cover over bedding.
8. Attach rubber adapter to metal tip of Miller-Abbott Tube leading to suction. (Page 219) LABEL: "To Suction".
9. Attach second rubber adapter to metal tip of Miller-Abbott Tube leading to balloon. LABEL: "To Balloon."
   a. Clamp adapter by folding over and securing with several twists of elastic band or adhesive.

INTESTINAL INTUBATION (Continued)

(Miller-Abbott Tube)

PROCEDURE (Continued)

10. Assist medical officer in passing tube.
    a. Have lubricant ready.
    b. Give patient sips of water when directed.
    c. Encourage patient to breathe through mouth.
11. When the tube is inserted to the desired level connect to suction-siphonage apparatus as follows:
    a. Attach Y tube to open end of adapter marked "to suction."
    b. Connect one arm of Y tube to suction-siphonage apparatus. The other end is used for irrigating the tube. Apply a rubber tip and clamp when not in use.
12. In order to advance the tube, turn patient on right side and advance the distance prescribed.
13. Tape tube to side of face.
14. The medical officer will inflate balloon with air, water or mercury after it has passed into the intestine.
15. To irrigate tube:
    a. Clamp tube leading to suction-siphonage apparatus.
    b. Open clamp on irrigating arm of Y tubing and irrigate.
16. Keep accurate intake-output record.
17. Chart time tube was inserted, by whom and patient's reaction on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Check for and remove dentures before tube is passed.
2. The medical officer will insert and remove Miller-Abbott tube.
3. Give frequent oral and nasal hygiene.
4. Never disturb rubber adapter leading to balloon.

CARE OF EQUIPMENT

1. Disconnect drainage bottle and tubing from suction-siphonage apparatus. Measure and record contents. Wash, rinse, and dry.

INTESTINAL INTUBATION (Continued)

(Miller-Abbott Tube)

CARE OF EQUIPMENT (Continued)

2. Use syringe to force warm soapy water through tube. Rinse well.
3. Return tube and suction apparatus with bottles to CSR.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

Standard Form 510
Rev. Feb. 1958
Bureau of the Budget
Circular A—32
Stock No. 1-0109-201-2304

SAMPLE CHARTING

GI TREATMENTS

CLINICAL RECORD — **NURSING NOTES** *(Sign all notes)*

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1973			GAVAGE
17 MAR	0900		LEVIN TUBE INSERTED BY DR. STEELE. SEEMS VERY
			FRIGHTENED ASKING, "HOW WILL I BE ABLE TO STAND
			THIS?" APPEARS LESS ANXIOUS AFTER DISCUSSING
			THE NEED FOR NUTRITIONAL MAINTENANCE WITH
			LT BURSON. TUBE CLAMPED. John Johner HN, USN
	1000		BLENDED TUBE FEEDING 400 cc. GIVEN. WATER
			60 cc ADDED TO CLEAR TUBING. TUBING CLAMPED.
			SEEMS RELIEVED THAT PROCEDURE WENT WELL.
			Ann Burson LT, NC, USN
			INTESTINAL INTUBATION
18 MAR		1400	ABDOMEN APPEARS VERY DISTENDED. DR. MILLER
			NOTIFIED. RECTAL TUBE INSERTED WITH NO RELIEF
		1435	TO X-RAY BY GUERNEY FOR FLAT PLATE OF ABDOMEN.
		1455	PROJECTILE EMESIS OF 240 cc. OF BROWN FLUID
			HAVING A FECAL ODOR. DR. MILLER NOTIFIED.
		1515	MILLER-ABBOTT INSERTED BY DR. MILLER. TUBE
			ATTACHED TO GOMCO SUCTION. ABOUT 280 cc. BROWN
			FLUID OBTAINED AT THIS TIME. Joseph Smith HM3, USN
		1600	FEELS "LESS SWOLLEN." ORAL HYGIENE GIVEN. NARES
			LUBRICATED. Carol Burns ENS NC USNR

Continue on reverse side

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO. 1-D

NURSING NOTES
Standard Form 510
510-107
PLATE NO. 10814 (REV.)

USE ADDRESSOGRAPH PLATE

PHELAN HAND PUMP SUCTION SIPHONAGE

PURPOSE

To provide constant suctioning of gastrointestinal tract.

EQUIPMENT

Hand pump suction apparatus
Y connecting tip
Rubber tubings (two 3-4 foot lengths, one 6 inch length)
Two clamps
Drainage bottle with glass tubing

PROCEDURE

1. Insert gastric tube according to directions given on page 214.
2. To assemble suctioning equipment:
   a. Insert two lengths of glass tubing through holes in rubber stopper of drainage bottle.
   b. Insert rubber stopper into gallon bottle. Be sure stopper fits tightly.
   c. Connect one length of rubber tubing to short glass tubing on stopper of drainage bottle; connect other end of this rubber tubing to gauge on tank.
   d. Connect one end of second length of rubber tubing to long glass tubing on stopper of drainage bottle; connect other end of this rubber tubing to long stem of Y connector.
   e. Connect gastric tube to one short arm of Y connector.
   f. Attach short rubber tubing with clamp to free arm of Y connector.
3. To start siphonage:
   a. Open needle valve on tank by turning knurled knob in counter clockwise direction (to left).
   b. Create suction in tank by pumping approximately 40 - 50 strokes until gauge registers 3 - 5 pounds.
4. Irrigate gastric tube as ordered by medical officer.
5. Record:
   a. Total gastric drainage on Intake and Output sheet every twenty-four hours.
   b. Time suction was started, irrigations, and character of returns on Nursing Notes (SF 510).

PHELAN HAND PUMP SUCTION SIPHONAGE (Continued)

POINTS TO EMPHASIZE

1. Watch gauge. Dial should read 3-5 pounds during treatment.
2. Collapse of the tube indicates too much suction.
3. If system is free of leaks, suction should be sufficient to last for 15-20 hours without repumping the tank.

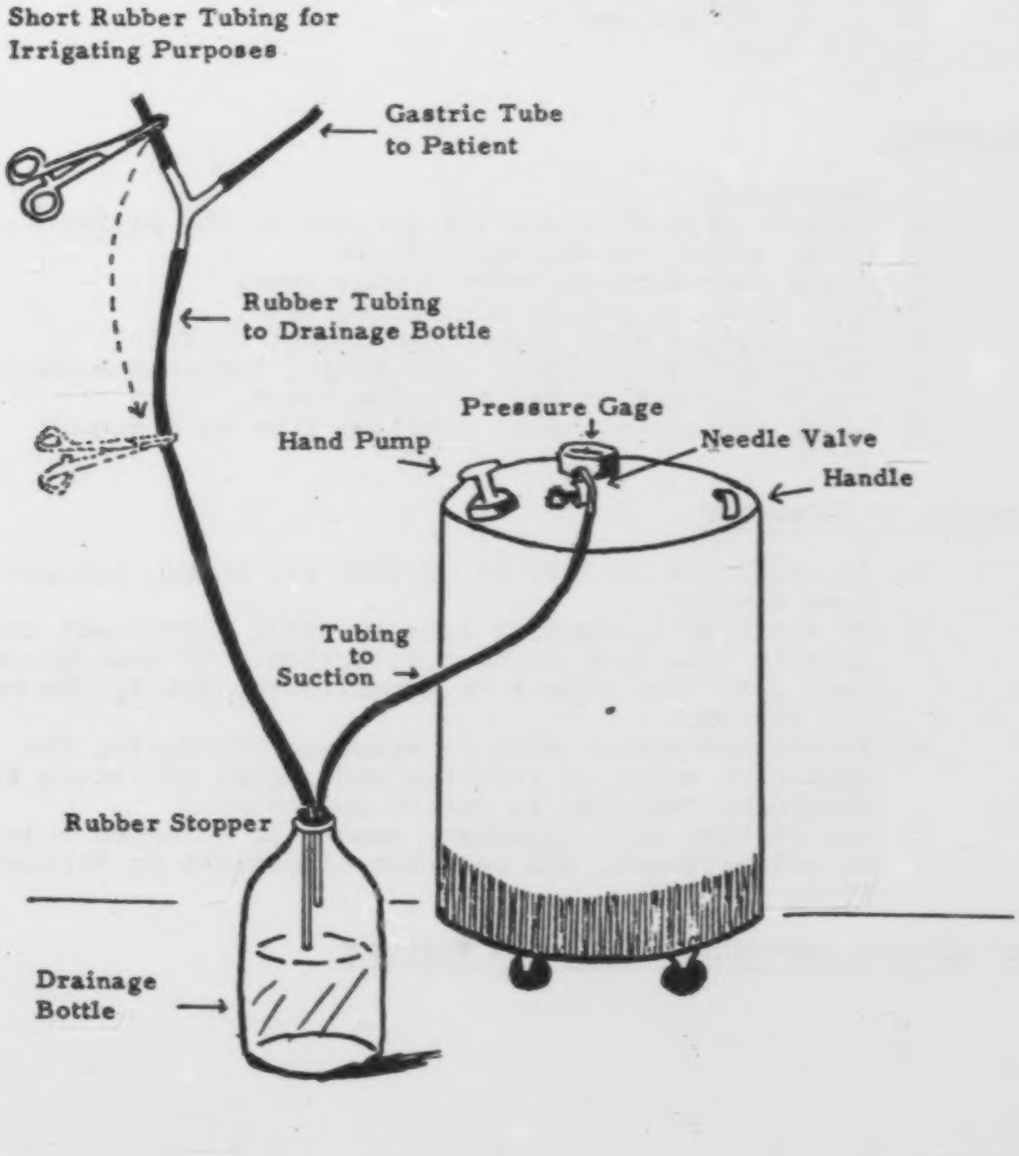
CARE OF EQUIPMENT

1. Wash drainage bottle and glass tubing every twenty-four hours.
2. Wash gastric equipment and return to CSR.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

HAND PUMP SUCTION APPARATUS

PHELAN-WANGENSTEEN


Short Rubber Tubing for Irrigating Purposes
Gastric Tube to Patient
Rubber Tubing to Drainage Bottle
Pressure Gage
Hand Pump
Needle Valve
Handle
Tubing to Suction
Rubber Stopper
Drainage Bottle

GASTRIC TUBE IRRIGATION

PURPOSE

To maintain patency of nasogastric tube.

EQUIPMENT

Basin of normal saline or water as ordered
20 or 30 cc. syringe
Curved basin
Clamp

PROCEDURE

1. Wash hands.
2. Explain procedure and its purpose to the patient.
3. Clamp tubing to drainage bottle.
4. Place curved basin under Y connector.
5. Open clamp on rubber irrigating tube.
6. Fill syringe with prescribed amount of solution. Inject solution slowly into tube. Aspirate slowly.
7. Repeat irrigation two or three times.
8. Clamp irrigating tube. Unclamp tube to drainage bottle.

POINTS TO EMPHASIZE

1. If equipment is left at bedside for hourly irrigations, keep covered.
2. If straight connecting tube is used, disconnect the gastric tube from connector. Irrigate in same manner.
3. When free flow cannot be established, notify the medical officer.
4. Intake and output must be measured carefully. The amount of solution injected and amount of return flow should be recorded as intake and output.
5. Record time of irrigation, amount of solution injected and returned, and reaction of patient on Nursing Notes (SF 510).

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PERITONEAL LAVAGE/DIALYSIS

PURPOSE

To aid in the removal of waste products when the kidneys are malfunctioning.

EQUIPMENT

Peritoneal dialysis administration sets
Peritoneal catheter
Peritoneal dialysis solutions
2 cc. and 10 cc. syringes
Hemostats or clamps
Paracentesis set
Infusion stand
Calibrated 1000 cc container, sterile
Operative Permit, SF - 522
Skin antiseptic
Sterile gloves
Gauze dressings
Adhesive tape
Scissors
Razor with blade
Glass marking pencil
Medications as ordered
Local anesthetic

PROCEDURE

1. Have operative permit signed.
2. Instruct patient as to what you are going to do.
3. Shave abdomen.
4. Have patient void or catheterize if necessary.
5. Take and record blood pressure and pulse.
6. Wash hands.
7. Bring equipment to bedside.
8. Place patient in supine or semi-supine position.
9. Prepare solutions:
   - a. Heat 2000 cc dialysis solution to approximately body temperature but no warmer.
   - b. Add medication to solution as ordered. Label.
   - c. Mark fluid level on both bottles.
   - d. Attach tubing to each bottle and hang on infusion stand.
   - e. Fill tubing with solution. Clamp.

PERITONEAL LAVAGE/DIALYSIS (Continued)

PROCEDURE (Continued)

10. Assist medical officer. Prepare paracentesis tray and peritoneal catheter.
11. Unclamp tubing after catheter has been connected.
    a. Allow solution to flow into abdomen as rapidly as possible, 5 - 10 minutes for completion.
12. Clamp tubing when bottles are emptied. Leave tubing filled with solution.
13. Remove bottles from infusion stand and place in bottle carrier attached to bed.
14. Secure tubing to side of bed to prevent kinking.
15. Wait 60 to 90 minutes. Unclamp tubing and allow solutions to drain back into bottles.
16. Clamp tubing when bottles refill to previously marked fluid level.
17. Drain excess fluid into sterile calibrated container.
18. Begin second infusion just before measuring previous one. (Total drainage time about 15-20 minutes)
19. Repeat procedure until discontinued - usually 12 - 36 hours.

POINTS TO EMPHASIZE

1. Observe patient closely for state of consciousness and impending shock.
2. Avoid dislodging peritoneal catheter when providing nursing care.
3. Take and record pulse and blood pressure every 10 - 15 minutes unless otherwise ordered.
4. Report any pain, discomfort or bleeding.
5. Maintain accurate intake and output record.
6. If amount of withdrawn fluid does not correspond closely with amount infused, notify medical officer.
7. Prepare additional solution bottles in advance and be prepared to administer as soon as previous one is completed.
8. Retain used bottles and excess fluid for medical officer to inspect.
9. Record starting and completion times for each change and when drugs are added.

SPECIAL CHARTING

1. Precise amount and time infusions are started and completed, and character and amount of drainage.
2. All medications and solutions used.
3. Vital signs and other observations.

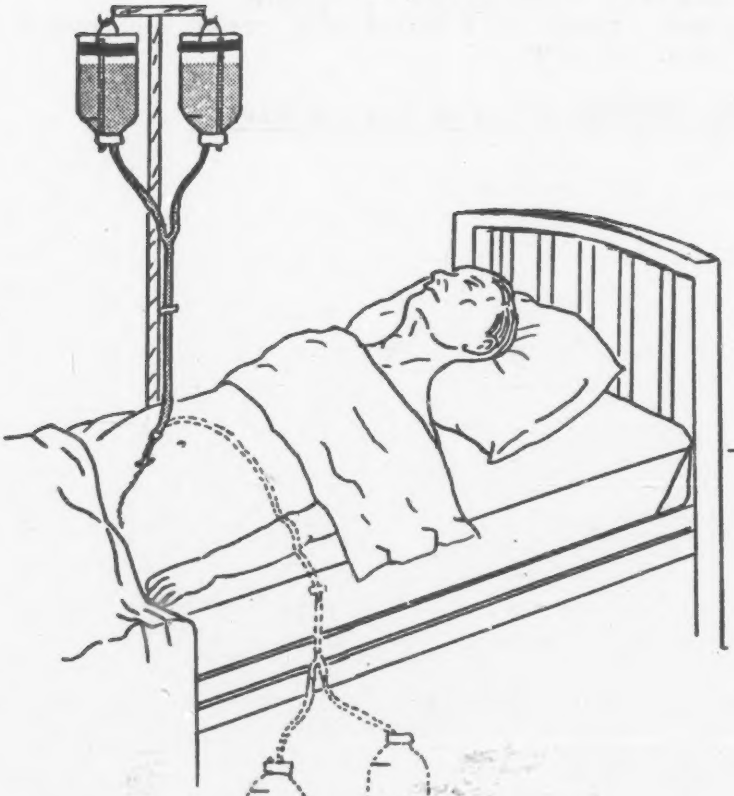
PERITONEAL LAVAGE/DIALYSIS (Continued)

CARE OF EQUIPMENT

1. Retain used solution bottles and excess fluid until disposition is directed by medical officer.
2. Discard disposable equipment.
3. Wash, rinse and disinfect other equipment and return to CSR.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PERITONEAL LAVAGE/DIALYSIS



OXYGEN BY TENT

PURPOSE

To provide a high concentration of oxygen by inhalation.

EQUIPMENT

Oxygen by cylinder or wall outlet.
Oxygen tent
Gauge and rubber tubing
Nonmagnetic wrench
Two cotton blankets
Cotton sheets
Hand bell
"NO SMOKING" signs

PROCEDURE

1. "Crack" cylinder outside of the room. Attach gauge and tubing. Use nonmagnetic wrench.
2. Open cylinder valve to check for leaks. Close valve.
3. Check canopy and tent tubing for holes.
4. Wash hands. Tell the patient what you are going to do.
5. Use cotton blanket to cover patient.
6. Replace electric call signal with hand bell.
7. Place "NO SMOKING" signs at entrance to unit and at bedside.
8. Take tent and oxygen to bedside. Secure cylinder to carrier or bed with two straps.
9. Connect tent to oxygen.
10. Place 3-prong safety plug into grounded electrical outlet.
11. Set gauge valve for 15 liters.
12. Place canopy over upper part of bed. Tuck well under mattress at sides and head of bed. Bring front down over patient.
13. Fold cotton sheet in fourths. Place front edge of canopy within folds of sheet. Tuck in under mattress at both sides.
14. Reduce oxygen flow to 10-12 liters in 20 minutes.
15. Test inside of tent for drafts by placing hand in various locations near patient's head.
16. Adjust temperature to 68 degrees or to patient's comfort.
17. Record time, treatment started, rate of oxygen flow, how administered, and effect of treatment on Nursing Notes (SF 510).

OXYGEN BY TENT (Continued)

POINTS TO EMPHASIZE

1. Check equipment frequently:
    a. Oxygen supply.
    b. Tent for leaks.
    c. Temperature.
2. See that the inflow tube or shutter is clear and not covered.
3. Keep extra cylinders of oxygen on hand. Follow local instruction for securing cylinder.
4. Remove patient from canopy if electricity fails.
5. Start flow of oxygen before placing patient in tent.
6. Do not use oil, give alcohol rubs, use wool blankets or electrical devices while patient is in oxygen tent.
7. Take rectal temperatures while patient is in oxygen tent.

CARE OF EQUIPMENT

1. Remove tent. Close valves on gauge and cylinder.
2. Wash tent with soap and water, rinse and dry.
3. Remove gauge. Cap the cylinder. Attach label indicating the amount of oxygen remaining.
4. Return equipment to CSR or oxygen therapy department.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

OXYGEN BY MASK

PURPOSE

To administer a higher concentration of oxygen to the patient than is available in the atmosphere or in an oxygen tent.

EQUIPMENT

Oxygen by cylinder or wall outlet
Gauge
Four feet of rubber tubing
Nonmagnetic wrench
"NO SMOKING" signs
0_2 mask

PROCEDURE

1. Tell patient what you are going to do.
2. "Crack" cylinder outside of room. Attach gauge with nonmagnetic wrench.
3. Connect tubing and mask.
4. Open cylinder valve and check for leaks in equipment.
5. Take equipment to bedside. Secure cylinder to bed or carrier.
6. Post "NO SMOKING' signs at entrance of ward or room, and at bedside.
7. Turn on oxygen. Adjust flow as ordered, 6 to 8 liters per minute.
8. Place mask on patient's face. Adjust head band so mask fits snugly.
9. Remove mask every 1 to 1 1/2 hours. Sponge and dry patient's face and inside of mask. Reapply mask.
10. Record time, rate of flow of oxygen, how administered, and effect of treatment on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Check mask around edges for leakage. A small piece of gauze or cotton over bridge of nose or chin may be necessary to prevent leakage.
2. Watch breathing bag. It should inflate when patient exhales and deflate when patient inhales.
3. A humidifier is not usually used when administering oxygen by mask. Moisture that collects within the mask from the patient's exhalations usually provides enough humidification for the oxygen.

OXYGEN BY MASK (Continued)

CARE OF EQUIPMENT

1. Remove mask. Close valves on gauge and cylinder.
2. Wash mask with soap and water. Rinse and dry.
3. Cap the cylinder and attach label indicating the amount of oxygen remaining.
4. Return all equipment to CSR or O_2 therapy department.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

OXYGEN BY CATHETER

PURPOSE

To administer a higher concentration of oxygen than is available in the atmosphere.

EQUIPMENT

Oxygen by cylinder or wall outlet
Gauge and humidifier
Oxygen catheter, rubber/plastic
Four feet of rubber tubing
Nonmagnetic wrench
Water soluble lubricant
Paper wipes
"NO SMOKING" signs
Tongue blades
Flashlight
Adhesive tape

PROCEDURE

1. Tell patient what you are going to do.
2. Crack cylinder outside of room.
3. Fill humidifier to fluid level with distilled water.
4. Connect gauge, humidifier and tubing to cylinder with nonmagnetic wrench.
5. Open cylinder valve, check for leaks.
6. Take equipment to bedside. Secure cylinder to carrier or bed.
7. Post "NO SMOKING" signs at entrance to unit and at bedside.
8. Attach catheter to oxygen supply.
9. Measure distance from tip of patient's nose to lobe of ear. Mark this point with adhesive tape.
10. Lubricate catheter tip sparingly.
11. Turn on oxygen. Adjust flow. (5-8 liters per minute)
12. Insert catheter into patient's nostril slowly.
13. Ask patient to open his mouth. Use tongue blade and light to check position of the catheter. The tip should be seen just opposite the uvula when it is in the correct position.
14. Tape catheter at side of patient's temple and at bridge of nose.
15. Secure tubing to the bed leaving sufficient tubing to allow the patient free movement in bed.
16. Record time, rate of oxygen flow, how administered, patient's reaction and effect of treatment on Nursing Notes (SF 510).

OXYGEN BY CATHETER (Continued)

POINTS TO EMPHASIZE

1. Distilled water MUST be used in the humidifier.
2. Change catheter every 12 hours. Insert clean one in opposite nostril.
3. It is extremely important that tip of catheter rests just opposite the uvula.
4. Check tubing frequently to make sure it is not pinched or kinked.

CARE OF EQUIPMENT

1. Close valve on gauge and cylinder.
2. Remove gauge. Empty humidifier.
3. Cap cylinder, attach label indicating amount of oxygen remaining.
4. Wash catheter and return to CSR or discard disposable ones.
5. Return all equipment to CSR or Oxygen Therapy Department.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

OXYGEN BY NASAL INHALER

PURPOSE

To administer a higher concentration of oxygen to the patient than is available in the atmosphere.

EQUIPMENT

Oxygen by cylinder or wall outlet
Gauge and humidifier
Nonmagnetic wrench
Four feet of rubber tubing
Plastic nasal cannula
"NO SMOKING" signs

PROCEDURE

1. "Crack" oxygen cylinder outside of room.
2. Wash hands. Tell the patient what you are going to do.
3. Fill humidifier to fluid level with distilled water.
4. Connect the gauge, humidifier and tubing to cylinder.
5. Open valve and check for leaks in equipment.
6. Take equipment to bedside, secure cylinder to carrier or bed with straps.
7. Post "NO SMOKING" signs at entrance to unit and at bedside.
8. Attach cannula to oxygen supply.
9. Adjust flow of oxygen as ordered. Nine liters per minute is average.
10. Insert nasal tips into patient's nostrils. Secure in place.
11. Adjust headband above patient's ears to prevent slipping.
12. Record time, rate of oxygen flow, how administered, and effect of treatment on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Distilled water MUST be used in the humidifier.
2. Check position of nasal tips when patient moves about in bed.

CARE OF EQUIPMENT

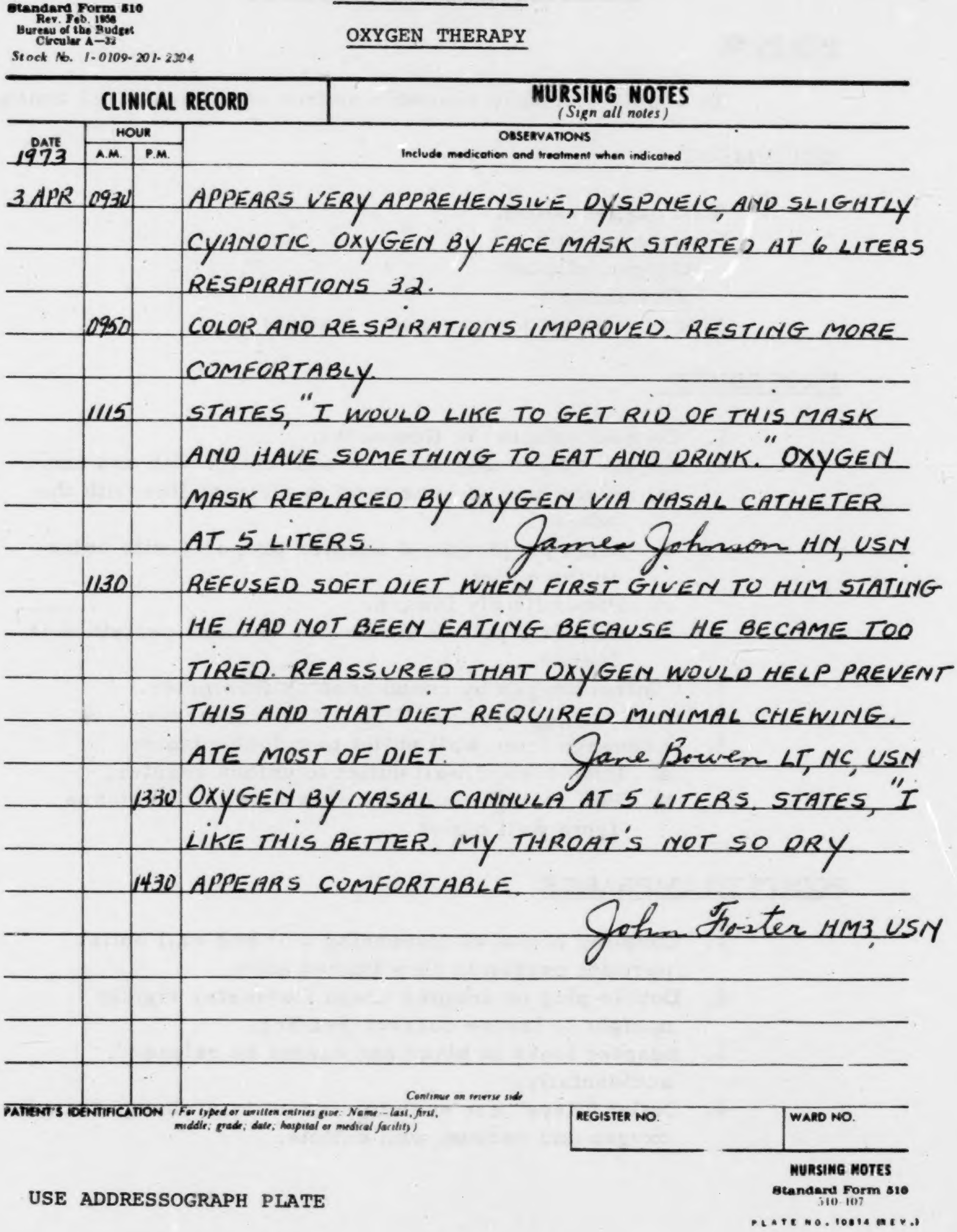
1. Close valves on gauge and cylinder. Remove the cannula.
2. Remove gauge. Empty humidifier.
3. Cap the cylinder. Attach label indicating amount of oxygen remaining.
4. Return all equipment to CSR or Oxygen Therapy Department.

OXYGEN BY NASAL INHALER (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SAMPLE CHARTING

OXYGEN THERAPY



Standard Form 510
Rev. Feb. 1956
Bureau of the Budget
Circular A—32
Stock No. 1-0109-201-2304

CLINICAL RECORD — **NURSING NOTES** *(Sign all notes)*

DATE 1973	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 APR	0930		APPEARS VERY APPREHENSIVE, DYSPNEIC, AND SLIGHTLY CYANOTIC. OXYGEN BY FACE MASK STARTED AT 6 LITERS RESPIRATIONS 32.
	0950		COLOR AND RESPIRATIONS IMPROVED. RESTING MORE COMFORTABLY.
	1115		STATES, "I WOULD LIKE TO GET RID OF THIS MASK AND HAVE SOMETHING TO EAT AND DRINK." OXYGEN MASK REPLACED BY OXYGEN VIA NASAL CATHETER AT 5 LITERS. James Johnson HN, USN
	1130		REFUSED SOFT DIET WHEN FIRST GIVEN TO HIM STATING HE HAD NOT BEEN EATING BECAUSE HE BECAME TOO TIRED. REASSURED THAT OXYGEN WOULD HELP PREVENT THIS AND THAT DIET REQUIRED MINIMAL CHEWING. ATE MOST OF DIET. Jane Bowen LT, NC, USN
		1330	OXYGEN BY NASAL CANNULA AT 5 LITERS. STATES, "I LIKE THIS BETTER. MY THROAT'S NOT SO DRY."
		1430	APPEARS COMFORTABLE. John Foster HM3, USN

Continue on reverse side

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.

WARD NO.

USE ADDRESSOGRAPH PLATE

NURSING NOTES
Standard Form 510
510-107
PLATE NO. 10814 (REV.)

OXYGEN PIPING EQUIPMENT

PURPOSE

To supply a readily available source of oxygen at all times.

EQUIPMENT

Wall oxygen outlet.
Dispensing unit
    Oxygen adapter
    Flowmeter
Alarm bell unit (over nurse's station)

PROCEDURE

1. Connect adapter to flowmeter.
2. Engage dispensing unit into wall outlet with one hand.
   a. Place heel of your hand in a direct line with the adapter.
   b. Align projection of adapter properly with holes in the outlet.
   c. Press firmly inward.
   d. GENTLY pull on flowmeter to make certain it is locked.
3. Control oxygen by round knob on flowmeter.
4. Read oxygen liters at TOP of flow indicator.
5. Disengage from wall outlet to unlock adapter.
   a. Push toward wall outlet to unlock adapter.
   b. Pull straight back and flowmeter will release from wall outlet.

POINTS TO EMPHASIZE

1. Coupling action of dispensing unit and wall outlet permits oxygen to flow immediately.
2. Double plug on adapter keeps flowmeter rigidly upright to insure correct reading.
3. Adapter locks in place and cannot be released accidentally.
4. Outlet "Keys" are such to prevent interchange between oxygen and vacuum wall outlets.

OXYGEN PIPING EQUIPMENT (Continued)

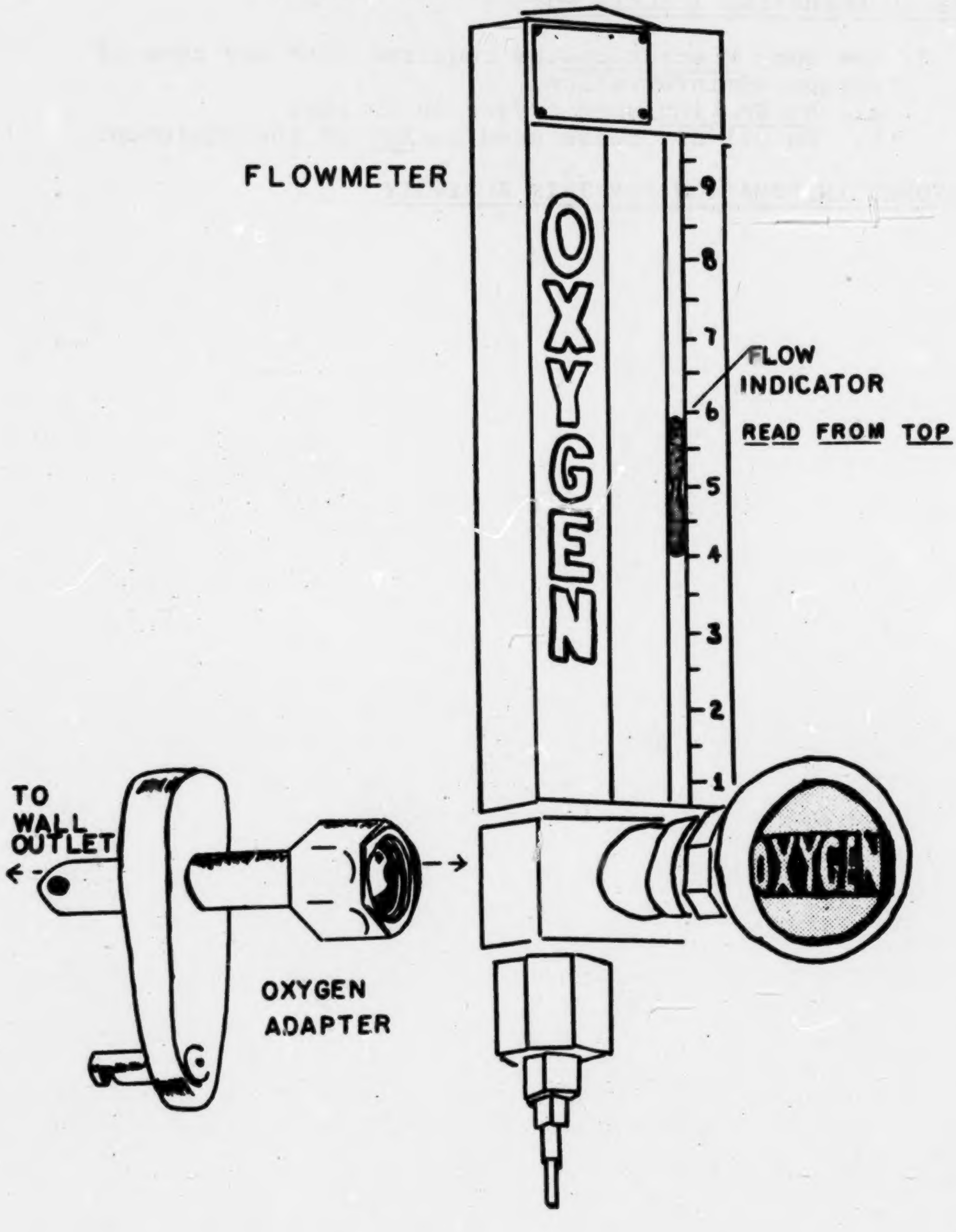
POINTS TO EMPHASIZE (Continued)

5. Use same Precautions as required with any type of oxygen administration.
   a. No Smoking when oxygen is in use.
   b. No Oil or Grease used on Any of the Equipment

ADDITIONAL INFORMATION FOR THIS ACTIVITY

OXYGEN PIPING EQUIPMENT

(National Cylinder Company)


FLOWMETER
OXYGEN
9
8
7
6
5
4
3
2
1
FLOW INDICATOR
READ FROM TOP
TO WALL OUTLET
OXYGEN
OXYGEN ADAPTER

OXYGEN BY FACE TENT

(Puritan Face Mask)

PURPOSE

To provide a higher concentration of oxygen to the patient than is available in the atmosphere.

EQUIPMENT

Cylinder of oxygen, or wall oxygen outlet
Gauge and humidifier
Nonmagnetic wrench
Disposable tubing
Face Tent mask
"No Smoking" signs

PROCEDURE

1. Tell patient what you are going to do.
2. Wash hands. Connect oxygen source of supply as directed on page 237 (Oxygen Mask).
3. Post "No Smoking" signs.
4. Turn on oxygen supply. Adjust flow as ordered. 6 - 8 liters per minute.
5. Place mask on patient. Adjust straps behind head to hold securely in place.
6. Remove mask every 1 - 2 hours. Sponge and dry the patient's face and the interior part of the mask. Reapply mask.
7. Record time, rate of oxygen flow, how administered, and effect of treatment on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Check apparatus frequently for leaks.
2. High concentration of oxygen can be administered quickly and efficiently by this method.
3. Humidity and inhalation medications can be administered by this method.

CARE OF EQUIPMENT

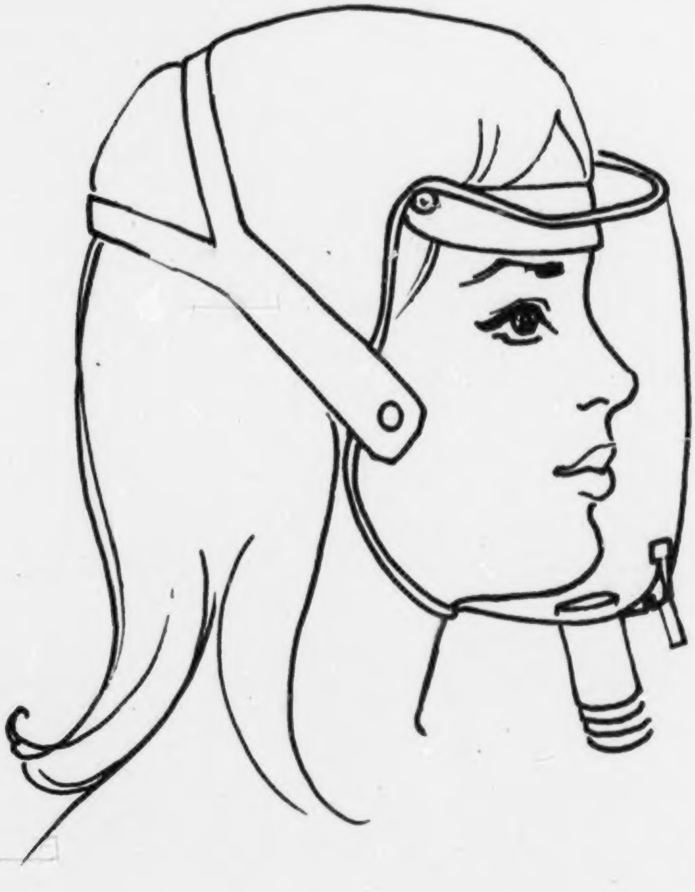
1. Return equipment to CSR or Oxygen Therapy Unit.
2. Discard disposable items.

OXYGEN BY FACE TENT (Continued)

(Puritan Face Mask)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

FACE TENT IN OXYGEN ADMINISTRATION



6-8 LITERS OF OXYGEN RECOMMENDED TO PREVENT AN EXCESS ACCUMULATION OF CARBON DIOXIDE.

AMBU RESUSCITATOR

PURPOSE

To restore respirations in an emergency situation.

EQUIPMENT

Ambu Resuscitator
- a. mask
- b. valve
- c. bag

PROCEDURE

1. Tilt head back to clear the airway.
2. Apply mask firmly to patient's face with rounded cushion between lower lip and chin and the narrow cushion as high on the bridge of the nose as possible.
3. Squeeze the bag firmly and watch the chest rise.
4. Release and let the patient exhale.
5. Repeat steps #3 and #4 (one second for inhalation and two seconds for exhalation).

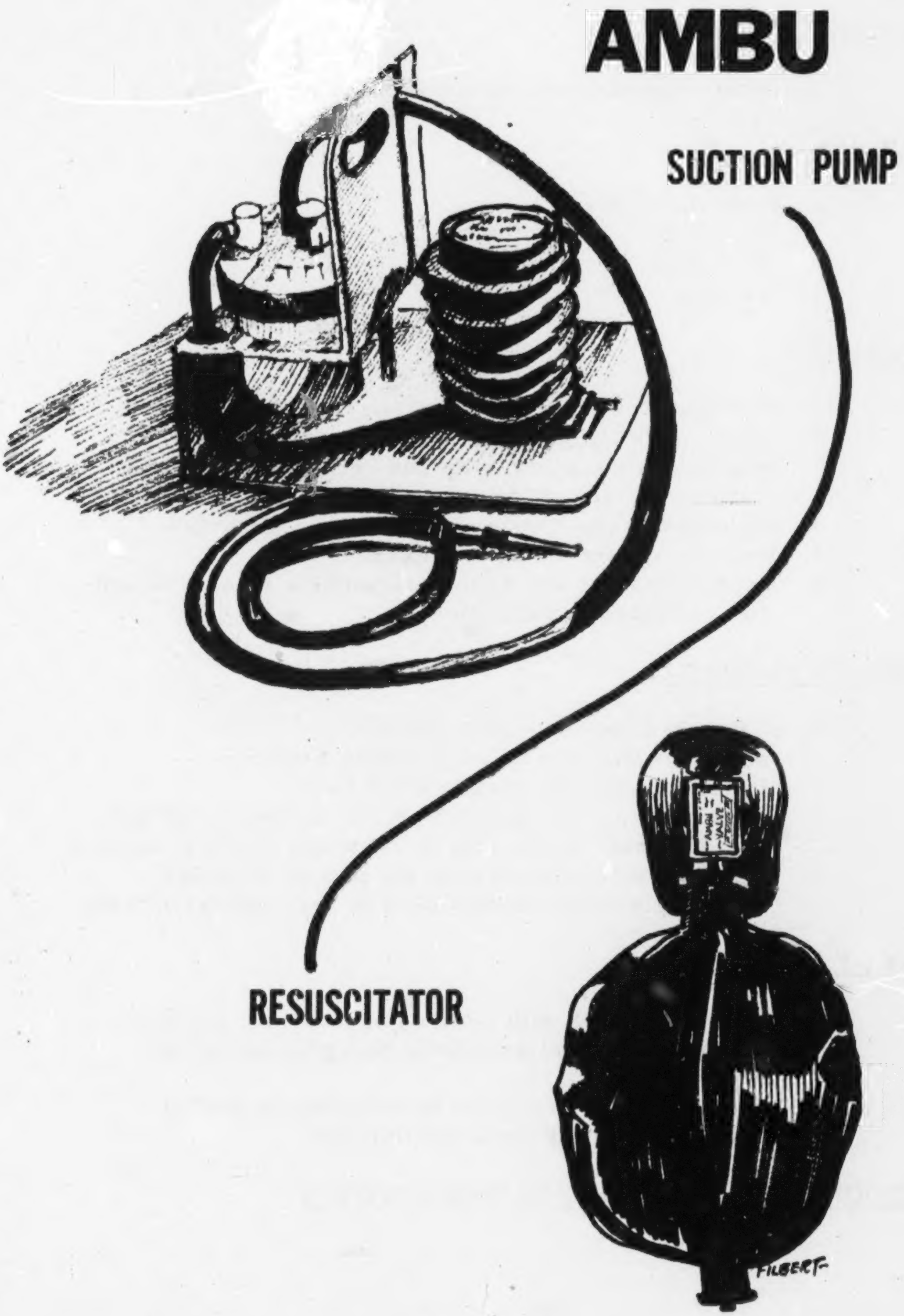
POINTS TO EMPHASIZE

1. If the chest does not rise and fall:
   - a. Make sure the mask is tightly fitted.
   - b. Make sure the head is tilted back.
   - c. Make sure the patient's throat is clear. (If not, turn head to the side to allow any fluids to drain.)
2. Continue resuscitation until the patient breathes naturally or until discontinued by the medical officer.

CARE OF EQUIPMENT

1. Clean face mask with cloth dampened with alcohol - or other chemical germicide that will not injure rubber.
2. After cleaning, dry valve by installing in AMBU bag and operating for a few minutes.

ADDITIONAL INFORMATION FOR THIS ACTIVITY


AMBU
SUCTION PUMP
RESUSCITATOR
FILBERT

MOUTH TO MOUTH AND MOUTH TO NOSE RESUSCITATION

PURPOSE

To restore breathing in an emergency situation.

PROCEDURE

Mouth to Mouth

1. Turn patient on back.
2. Turn head to the side. Remove any foreign bodies, mucus, etc. from mouth and throat.
3. Straighten patient's head. Tilt head back.
4. Pull jaw up into jutting out position.
5. Pull tongue forward.
6. Place your mouth tightly over patient's mouth. Pinch patient's nostrils.
7. Blow expired air into mouth of patient and observe for rise of chest.
8. Remove your mouth. Allow patient's lungs to empty while you are filling your lungs with air.
9. Repeat steps 6 through 8 at about 12-20 cycles per minute.
10. Continue until patient breathes for himself.

Mouth to Nose

1. Close off patient's mouth.
2. Blow your air through patient's nose into nasopharynx and the lungs.

POINTS TO EMPHASIZE

1. It may be necessary to place patient on abdomen and pat chest gently to dislodge foreign materials.
2. Free pharynx of foreign bodies or mucus before beginning resuscitation.
3. Jaw must be rotated forward during resuscitation to open airway to lungs.
4. Artificial respiration should be administered in a smooth steady cycle.
5. After every 20 cycles rest long enough to take one deep breath.

MOUTH TO MOUTH AND MOUTH TO NOSE RESUSCITATION(Continued)

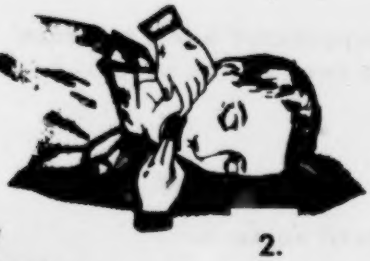
POINTS TO EMPHASIZE (Continued)

6. On inspiration take in approximately two times the normal volume of air.
7. Breathing through handkerchief or cloth placed over patient's mouth or nose will not greatly affect the exchange of air.
8. Air may be blown through patient's teeth, even though they may be clenched.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

RESCUE BREATHING

Mouth to Mouth (or Mouth to Nose) Rescue Breathing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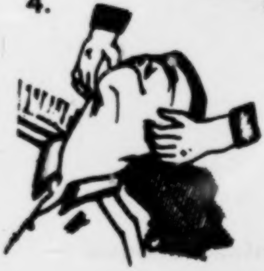
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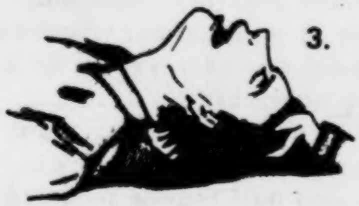
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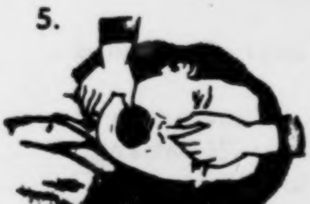
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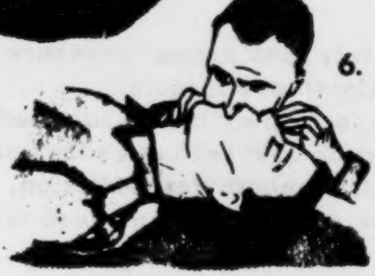

6.

1. Place casualty on back immediately. Don't waste time moving to a better place, loosening clothing, or draining water from lungs.
2. Quickly clear mouth and throat. Remove mucus, food and other obstructions.
3. Tilt head back as far as possible. The head should be in "chin-up" or "sniff" position and the neck is stretched. Place one hand beneath neck and tilt head with other.
4. If no results then lift lower jaw forward - or push up at angles of jaw.
5. Pinch nose shut (or seal mouth). Prevent air leakage.
6. Open your mouth wide and blow. Take a deep breath and blow carefully (except for babies) into mouth or nose until you see chest rise.
7. Listen for exhalation. Quickly remove your mouth when chest rises. Lift jaw higher if casualty makes snoring or gurgling sounds.
8. Repeat (6 and 7) 12 to 20 times per minute. Continue until casualty begins to breathe normally.
9. For infants seal both mouth and nose with your mouth. Blow with puffs of air from your cheeks.

CLOSED CARDIAC MASSAGE

PURPOSE

To restore circulation of oxygenated blood to brain within 3 to 5 minutes and to restore the normal heart beat.

EQUIPMENT

Wooden board or any flat hard surface
Defibrillating machine
Cardiac Monitor
Cardiac Arrest Sterile Tray

PROCEDURE

1. Diagnose cardiac arrest: absence of pulse, sudden pallor or cyanosis, sudden pupillary dilation, respiration standstill or apneac gasps, absence of blood pressure, EKG evidence of asystole (if EKG machine is immediately available).
2. Place wooden board under patient's upper trunk or place patient on floor or any hard flat surface.
3. Tilt patient's head back and pull tongue forward to maintain open airway.
4. Kneel over patient's chest and place heel of one hand directly over lower mid sternum.
5. Place heel of other hand over first hand and press down depressing sternum about 1 inch. (If patient is a child, less pressure is needed for depressing the sternum.)
6. Relax pressure immediately then repeat pressure at a rate of approximately 40 per minute.
7. Seek assistance in order to employ mouth to mouth resuscitation which must be carried out at the same time. When doing mouth to mouth resuscitation, breathe into patient when pressure is released on patient's chest.
8. Note exact time cardiac arrest began and exact time resuscitation began.

CLOSED CARDIAC MASSAGE (Continued)

POINTS TO EMPHASIZE

1. Note exact time of cardiac arrest.
2. Place patient on firm surface.
3. Secure assistance for mouth to mouth resuscitation.
4. Use rate of approximately 40 per minute.
5. Send for a doctor.
6. Send for defibrillating machine, cardiac monitor and cardiac arrest tray.
7. Once started, cardiac massage must be continued until regular heart beat resumes or until ordered discontinued by a medical officer.

Note: The term cardiac arrest is used to mean either complete heart stoppage or heart fibrillation. Either one or both of these conditions may occur. Fibrillation means the heart muscle is no longer beating in rhythm, or there is a completely irregular twitching and blood is not circulating. Irreversible damage to the brain may occur after 3 to 5 minutes due to lack of oxygenated blood.

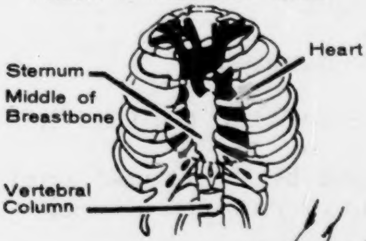
The defibrillating machine is used to electically shock a fibrillating heart to a complete standstill. After the heart is defibrillated then massage is instituted to restore the normal beat.

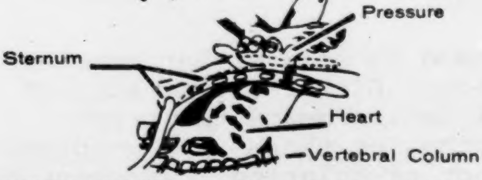
CARE OF EQUIPMENT

Clean and replace all equipment used.

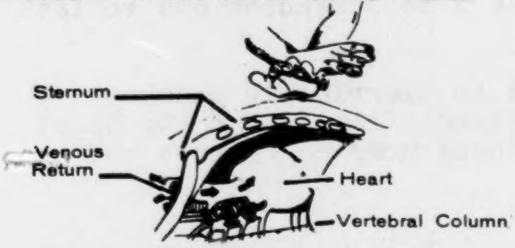
ADDITIONAL INFORMATION FOR THIS ACTIVITY

HEART & THORACIC CAGE

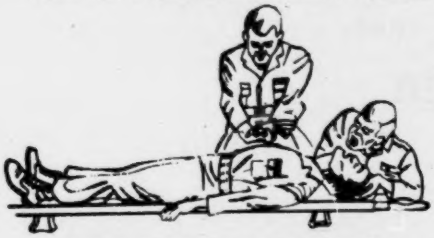

Sternum
Middle of Breastbone
Heart
Vertebral Column


Pressure
Sternum
Heart
Vertebral Column

PRESSURE FORCES BLOOD OUT OF HEART


Sternum
Venous Return
Heart
Vertebral Column

RELEASE PRESSURE - HEART REFILLS



HEART- LUNG RESUSCITATION — WHEN TWO PEOPLE ARE AVAILABLE

CLOSED CHEST MASSAGE OF THE HEART

1. Keep or place victim on his back on a firm surface.

2. a. Open patient's eyes--are pupils large?
   b. Check neck and wrist for pulse--if absent.
   c. Place ear on left side of victim's chest. Listen for heart sound--if absent.

START TREATMENT

3. Put heel of one hand on top of heel of other hand--and press on middle of victim's lower breast bone--NOT ON RIBS.

4. Press down firmly but gently 40-60 times per minute-with heel of hand ONLY.

CONTINUE

5. Check condition of victim by:
   a. Observe color of face and lips.
   b. Listen for heart beat on chest, check for pulse in neck.
   c. See if pupils are smaller.

6. CAUTION!!!
   a. Apply enough pressure to depress breast bone 1 1/2-2" except:
      (1) Children--use one hand and lighter pressure.
      (2) Newborn infants--only fingers and light pressure.
   b. Never breathe into victim while chest is being compressed.

HEART - LUNG RESUSCITATION

REMEMBER--SECONDS COUNT--DON'T WASTE TIME

2 AIDMEN

COUNT ALOUD 1, 2, 3, 4, BLOW TO SYNCHRONIZE ACTION WHEN STARTING.

#1 MAN (BLOW AFTER EACH 4th COMPRESSION BY #2)	#2 MAN COUNTS ALOUD
BLOW	
NOTE COLOR	1-2-3-4- COMPRESSIONS
BLOW	
CHECK NECK PULSE	1-2-3-4- COMPRESSIONS
BLOW	
CHECK EYES	1-2-3-4- COMPRESSIONS
BLOW	

CONTINUE

RATIO -- ONE BREATH PER FOUR COMPRESSIONS

1 AIDMAN

SCREAM FOR HELP OR CALL FOR HELP BY ANY AVAILABLE MEANS BUT DON'T WASTE TIME.

1. BLOW INTO VICTIM 5 TIMES.
2. COMPRESS CHEST APPROXIMATELY 30 TIMES.
3. CONTINUE REPEATING 1 AND 2 ALTERNATELY.
4. CHECK COLOR, NECK PULSE AND EYES WHEN POSSIBLE.

SUCTION UNITS AND VACUUM PRESSURE

(National Cylinder Company)

PURPOSE

To provide a convenient and efficient means of suction.

EQUIPMENT

Wall bracket unit:
  Wall vacuum outlet
  Vacuum adapter
  One-half gallon bottle
  Bottle cap assembly
  Holder
  Hose
  Safety keyed adapter
  Low Vacuum Regulator and Gauge assembly
  (0-200 mm. Mercury and 0-8 inches Mercury)

PROCEDURE

1. Engage adapter into Vacuum wall outlet.
2. Screw bottle securely against gasket in suction bottle cover.
3. Open Regulator to left and place finger over tubing outlet to check for the pressure of vacuum.
4. Attach catheter to tubing.
5. To discontinue:
   Turn regulator control to right. Unit may remain on wall outlet or be disengaged.

POINTS TO EMPHASIZE

1. Regulator Dial reads in millimeters and in inches of Mercury.
2. Adapter may be removed from outlet.
3. The float will rise and shut off vacuum when the fluid reaches a sufficient level. Make certain the float and stem are clean and move freely up and down.

SUCTION UNITS AND VACUUM PRESSURE (Continued)

(National Cylinder Company)

POINTS TO EMPHASIZE (Continued)

4. Do Not pull on stem as it will come out of the float guide completely. If this happens:
    a. Replace by removing float stem guide from bottle top.
    b. Replace stem in guide.
    c. Replace rubber seats on stem.
    d. Screw complete assembly to the jar top.

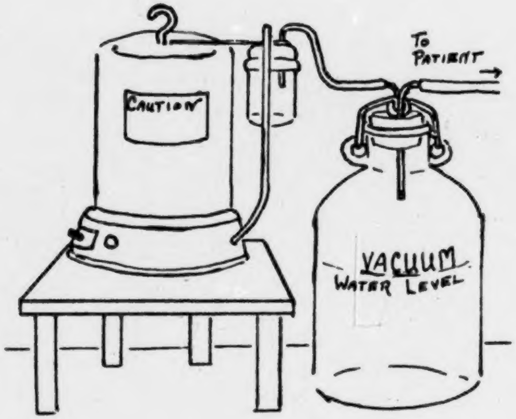
CARE OF EQUIPMENT

Empty bottle. Wash, dry. Replace on wall bracket.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SUCTION MACHINES

AUTOMATIC, THERMOTIC
(GOMCO)

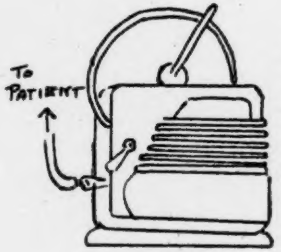


Function. Gentle intermittent suction for cavity drainage.

How to Use it:
1. Place aspirator above level of gallon drainage bottle.
2. Connect tube of drainage bottle to patient's tubing.
3. Turn on switch, to "Low." Red light will glow on and off.

Caution. Empty bottle before fluid reaches mark. If red light glows steadily. Obtain new unit.

STEDMAN

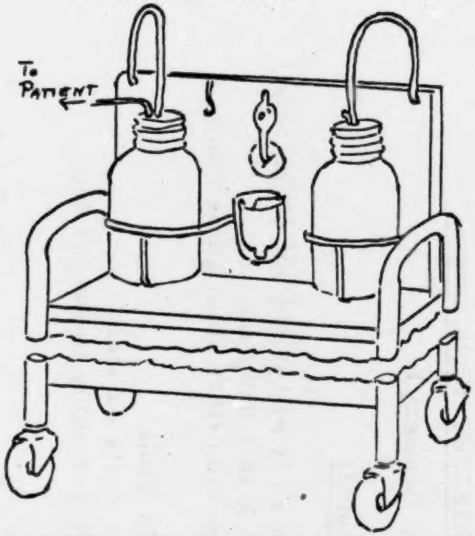


Function. Steady, gentle suction for cavity drainage.

How to Use it:
1. Obtain 2 pumps.
2. Turn on switch. Adjust pressure ordered.
3. Attach to patient's tubing.
4. Change pumps every hour: Clamp tubing. Turn off motor. Connect tubing to new pump. Turn on motor. Open tubing clamp after 10 seconds.

Caution. Pump may overheat - Change Q. hour.

CHAFFIN PRATT



Function. Gentle, steady, continuous suction. Is double on low range permitting two suctions on same patient or two patients on same machine.

How to Use it:
1. Obtain suction case with 2 one-half gallon collection bottles.
2. Connect tube from one collection bottle to tubing from the #2 chest bottle of water seal bottle set up.

Caution. Automatically on low suction. Other suction adjustment made only by medical officer.

INTERMITTENT POSITIVE PRESSURE BREATHING UNIT

(Bennett)

PURPOSE

To restore and maintain patency of the peripheral bronchial tree.

EQUIPMENT

Bennett Pressure Breathing Therapy Unit
Oxygen or Oxygen-Helium or Compressed Air
Prescribed medication or distilled water
Medicine dropper or 2 cc syringe
"No Smoking" signs

PROCEDURE

1. Attach Bennet Unit to oxygen.
2. Place prescribed medication or distilled water in Nebulizer with medicine dropper or syringe.
3. Put "No Smoking" signs at entrance to unit and/or at bedside.
4. Explain to patient what he is expected to do:
   - a. Sit upright.
   - b. Breathe in and out at rate and rhythm which is best for him.
   - c. Inhale deeply through mouth, then relax and exhale completely.
   - d. Watch Mask Pressure Gauge.
5. Turn on oxygen.
6. Make certain Nebulizer Needle Valve is closed.
7. Move the Shut-Off Lever down to "ON" position.
8. Turn the Pressure Control Knob until the gauge is set at the pressure prescribed (usually 12-20 cm.).
9. Adjust the Nebulizer Needle Valve until a fine mist is seen.
10. Apply mask or mouthpiece.

PROCEDURE (Continued)

11. Continue treatment for prescribed length of time. At completion:
    a. Remove mask or mouthpiece during exhalation.
    b. Have patient take two or three deep breaths of room air immediately.
    c. Move Shut-off lever up to "OFF" position.

POINTS TO EMPHASIZE

1. Observe same precautions as used with any other oxygen administration.
2. Stay with patient during initial treatments. Instruct and encourage him to perform this procedure.
3. If mask cushion seems deflated, open valve at bottom of mask for a few seconds - it is self filling.
4. Any mask leakage will make exhalation difficult. Fit mask with care.
5. Facial oils must be removed before applying mask to prolong life of cushion.
6. Use noseclip with mouthpiece until patient learns to breathe entirely through his mouth.
7. Manifold assembly must be kept in horizontal position to function correctly.

CARE OF EQUIPMENT

1. Remove flex tube and mask, nebulizer from manifold assembly.
2. Disconnect both large and small plastic tubes from manifold assembly. Allow to hang.
3. Remove manifold assembly by loosening knurled nut until the ball joint can be removed from socket. Not necessary to remove nut completely.

INTERMITTENT POSITIVE PRESSURE BREATHING UNIT (Continued)

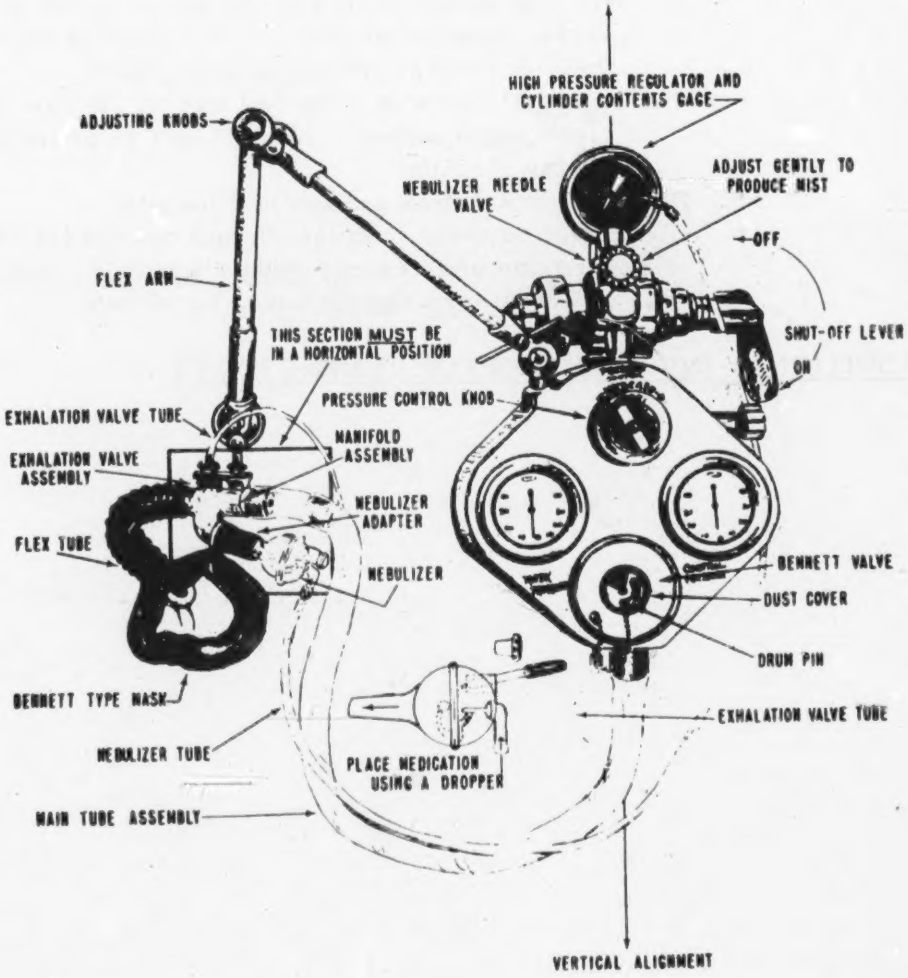
(Bennett)

CARE OF EQUIPMENT (Continued)

4. Wash Manifold Assembly:
    a. Prevent water from getting inside small rubber valve. Hold index finger over opening of small tube extending from exhalation valve.
    b. Wash all parts in soap and water. Rinse in clear warm water. Keep finger in position during rinsing.
5. Disinfect in solution prescribed locally.
6. Clean immediately. Moisture and chemicals cause slow erosion and destroy exhalation valve seat.
7. Plastic nebulizers should never be boiled.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

INTERMITTENT POSITIVE PRESSURE BREATHING UNIT
(Bennett)


HIGH PRESSURE REGULATOR AND CYLINDER CONTENTS GAGE
ADJUSTING KNOBS
ADJUST GENTLY TO PRODUCE MIST
NEBULIZER NEEDLE VALVE
OFF
FLEX ARM
SHUT-OFF LEVER
THIS SECTION MUST BE IN A HORIZONTAL POSITION
ON
PRESSURE CONTROL KNOB
EXHALATION VALVE TUBE
MANIFOLD ASSEMBLY
EXHALATION VALVE ASSEMBLY
NEBULIZER ADAPTER
FLEX TUBE
NEBULIZER
BENNETT VALVE
DUST COVER
DRUM PIN
BENNETT TYPE MASK
EXHALATION VALVE TUBE
NEBULIZER TUBE
PLACE MEDICATION USING A DROPPER
MAIN TUBE ASSEMBLY
VERTICAL ALIGNMENT

RESPIRATOR

(Bird Residual Breather)

PURPOSE

To provide nebulized medications to the respiratory tract.

EQUIPMENT

Bird Breather and attachments
Oxygen/compressed air
Prescribed medication
"NO SMOKING" sign
Nonmagnetic wrench
Medicine dropper/2 cc syringe and needle

PROCEDURE

1. Connect pressure reducing regulator to oxygen. Have regulator gauge pointing up.
2. Join Bird Breather to regulator by turning wing nut clockwise.
3. Prepare prescribed solution. Place in nebulizer.
4. Insert metal tip of green tubing into nebulizer. Do not force tubing on tip.
5. Check proper nebulizer functioning:
    a. Hold horizontal, inlet pointing to floor.
    b. Switch breather on with hand timer. Vapor should appear.
6. Connect nebulizer to one end of cross bar of plastic "T".
7. Place mouthpiece or mask in other end of "T".
8. Connect "T" to exhalation valve assembly. Hang assembled unit on hook.
9. Turn pressure knob initially to prescribed pressure.
    a. Push "Air-Mix" knob in for oxygen.
    b. Pull out for 40% oxygen-air mixture.
10. Turn automatic timer off clockwise.

PROCEDURE (Continued)

11. Test flow. Turn control flow rate knob one turn counterclockwise.
    a. Turn sensitivity control knob counterclockwise (screws knob out) until Bird Breather switches on and off by itself.
    b. Follow by turning knob clockwise (inward) until cycling stops and Bird Breather remains off.
12. Explain procedure and its purpose to patient.
13. Select mask or mouthpiece.
14. Open valve on oxygen.
15. Set flow rate wheel for best patient comfort and needs. Have patient take few breaths. Keep gauge needle in green part of the two colored dials.
16. Recheck flow rate:
    a. Reduce rate enough to swing gauge needle into red half of dial or until flow will not stop.
    b. Increase flow rate to level that keeps gauge needle in green half while breathing in.
    c. Use hand timer to start flow.
17. Proceed with treatment.

POINTS TO EMPHASIZE

1. Observe same precautions as required with any oxygen administration.
2. Pressure and flow rate should be low and gradually increased during treatment just enough to fill total lung volume without extending the filling time.
3. If patient is lying down, "T" must be rotated 90° and nebulizer moved to horizontal position.
4. Pressure is registered in the two color gauge dial - positive within the green half; negative within the red.
5. Do not force hand timer. It is a sensitive instrument.

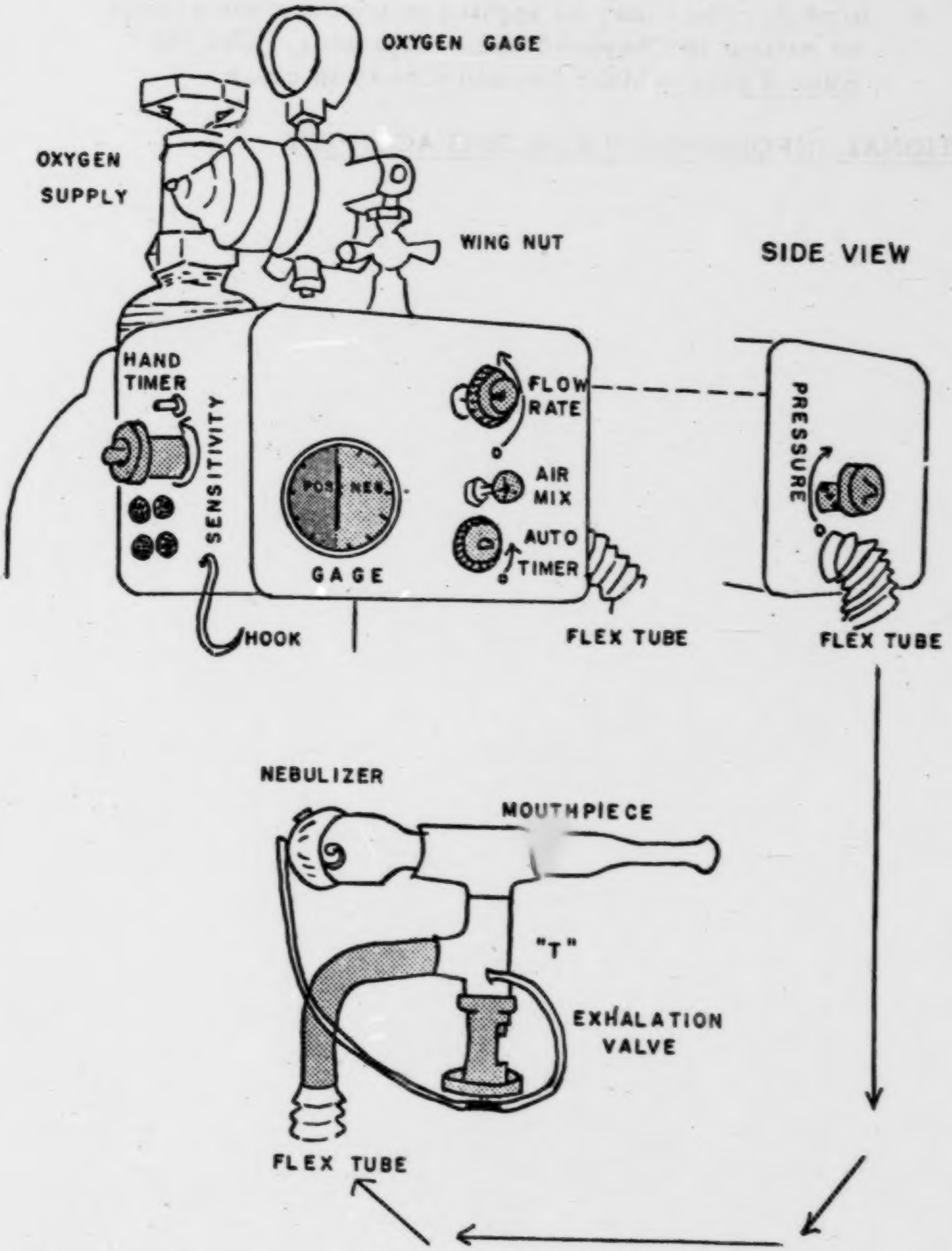
RESPIRATOR (Continued)

POINTS TO EMPHASIZE

6. Bird Breather may be applied to unconscious patient or patient in Cheyne-Stokes respirator. Use the Auto-Timer. Make certain airway is clear.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

RESPIRATOR
(Bird Residual Breather)


OXYGEN GAGE
OXYGEN SUPPLY
WING NUT
SIDE VIEW
HAND TIMER
SENSITIVITY
FLOW RATE
POS
NEG
AIR MIX
AUTO TIMER
GAGE
PRESSURE
HOOK
FLEX TUBE
FLEX TUBE
NEBULIZER
MOUTHPIECE
"T"
EXHALATION VALVE
FLEX TUBE

CHEST PHYSICAL THERAPY

PURPOSE

To assist the normal clearing mechanism of the tracheobronchial tree.

COMPONENTS

1. Bed positioning
2. Breathing exercises
3. Postural drainage
4. Manual techniques

BED POSITIONING: Should be part of preoperative teaching plan.

When sitting or propped up in bed, with back supported, the patient should keep the pelvis level and take the body weight equally on each buttock. The shoulders should be level and evenly placed over the hips. This position is important for free excursion of both sides of the chest as well as for promotion of good posture.

BREATHING EXERCISES: Should be taught preoperatively if applicable.

A. Types
   1. Diaphragmatic - The patient is taught to expand his abdomen on inspiration, allowing greater diaphragmatic excursion by releasing visceral pressure on the diaphragm. This process is reversed during expiration. The abdominal muscles are contracted increasing visceral pressure against the diaphragm, and decreasing lung capacity.
   2. Unilateral basilar restrictive exercise - If one side of the patient's chest is moving less well, light pressure is applied by the nurse/corpsman's hands over the lower lateral aspect of the patient's rib cage on the affected side. This pressure is applied at the end of expiration, calling the patient's attention to the area to be expanded. The patient continues to expand against light, but steady pressure during inspiration. Working against pressure helps strengthen the weakened inspiratory muscles, as it is a form of resistive active movement, and will thus increase mobilization of the rib cage. The amount of pressure to be applied will vary from patient to patient.
   3. Bilateral basilar chest expansion - Light pressure is applied by the nurse/corpsman's hands over the lower lateral aspect of the patient's rib cage. This pressure is applied at the end

BREATHING EXERCISES (Continued)

A. Types
    3.
        of expiration and the patient continues to expand against light, but steady pressure during inspiration. Patients should not do bilateral basal expansion until both sides of the chest are moving equally.

B. Uses
- 1. Preventive
    - a. Preoperative teaching
        - 1. Bed positioning.
        - 2. Breathing exercises.
        - 3. Postural drainage.
    - b. Postoperative utilization in surgical patients
    - c. The immobilized patient
- 2. Therapeutic
    - a. Acute
        - 1. Postoperative complications.
        - 2. Chest trauma.
        - 3. Pulmonary complications associated with immobilization.
    - b. Chronic
        - 1. Chronic obstructive lung disease.
        - 2. Neurological diseases affecting the muscles of respiration.
        - 3. Prolonged treatment in remobilizing some area of the thoracic cage.

POSTURAL DRAINAGE: Based on knowledge of bronchopulmonary segmental anatomy. Positions should be taught to the patient preoperatively when possible.

A. Purpose and General Principles:
1. Postural drainage assists the normal clearing mechanism of the lungs in moving secretions from the small bronchi into the main bronchi so that they may then be removed by coughing or tracheal suctioning. One of the forces which mobilizes these secretions is gravity, so the segment involved must be higher than the bronchi through which the secretions pass to reach the trachea.
2. There are positions that may be instituted for each individual segment of the lung. In the classical drainage position, the bronchus serving the affected segment is perpendicular to the floor, allowing for straight drainage, and unplugging of the airway.

CHEST PHYSICAL THERAPY (Continued)

POSTURAL DRAINAGE (Continued)

A. Purpose and General Principles:

3. Position which the patient will assume is determined by the segments involved. Segments involved are determined by auscultation and X-ray. Only the positions specifically needed are used.

B. Contraindications:

The classical drainage position for each segment is diagrammed on the following pages, but these may need modification as directed by the patient's tolerance and additional medical problems. If a patient cannot tolerate the desired position, it is better to compromise and turn him from side to side, with the bed flat.

C. Points to Emphasize:

1. Lobes most often affected are left lingular lobe, right middle lobe, and left and right lower lobes. The left and right upper lobes are rarely affected.
2. Provide disposable tissues and an emesis basin within easy reach.
3. Check patient's color, respirations, pulse, and blood pressure before having him assume a drainage position. Frequent monitoring of the patient's vital signs may be necessary during the treatment.
4. The length of time in each position is determined by the patient's need and tolerance.
5. ANY PATIENT RECEIVING CONTINUOUS OXYGEN THERAPY MUST CONTINUE TO RECEIVE OXYGEN DURING ENTIRE TREATMENT.
6. Patient with endotracheal tubes in place receiving postural drainage in a Trendelenburg position must have breath sounds checked bilaterally after being placed in this position.
7. Sputum samples, when ordered, should be taken following vibration.

MANUAL TECHNIQUES: May be employed to assist in the removal of secretions while the patient is in the appropriate drainage position.

A. Percussion: The nurse/corpsman's hands are cupped when applying percussion, so that there is a cushion of air between the nurse's hands and the patient's chest. The clapping or percussion of the patient's chest wall, over the segment involved, is carried out in a relaxed and rhythmical motion throughout the entire respiratory cycle - inspiration and expiration.

CHEST PHYSICAL THERAPY (Continued)

MANUAL TECHNIQUES (Continued)

1. Use:
   To remove tenacious secretions
2. Contraindications:
   a. Pulmonary hemmorrage
   b. Increase in pain
   c. Increase in bronchospasm

B. Vibrations: The nurse/corpsman's hands are placed firmly on the patient's chest wall, over the segment involved. The nurse's arm and shoulder muscles are then tensed until vibration of her hands occurs. These vibrations are applied to the patient's chest wall DURING EXPIRATION while lightly pressing inward on the patient's chest.

1. Use:
   To loosen inspissated secretions, helping to move them into larger airways where they can be more effectively removed.
2. Points to Emphasize:
   a. Vibrations are applied ONLY during expiration and over the segment involved.
   b. When only vibrations are employed, not percussion, have the patient inspire deeply, and vibrate during expiration. Repeat vibrations for 4-5 additional consecutive expirations, then instruct the patient to cough productively for approximately one minute before repeating vibrations.
   c. Sputum samples should be taken during productive coughing following vibration.

ORDERING CHEST PHYSICAL THERAPY:

Chest Physical Therapy is ordered with a thorough knowledge of the patient's needs, and is tempered by the other aspects of his illness that might contraindicate various positions and techniques.

1. Chest Physical Therapy is to be ordered specifically by a physician for a specific patient. A sample Chest Physical Therapy Instruction Sheet that can be used is found on page 269.
2. As with other Doctor's Orders, this treatment is to be reevaluated periodically and should be discontinued when no longer indicated.

CHEST PHYSICAL THERAPY FOR PATIENTS ON VENTILATORS:

Patients on mechanical ventilators need some form of postural drainage with or without vibration. Postural drainage may simply be done by changing the patient's

CHEST PHYSICAL THERAPY FOR PATIENTS ON VENTILATORS (Continued)

position frequently but purposefully, or it may be having the patient assume a classical drainage position for the segment involved.

Vibration, when synchronized with a mechanical ventilator, is performed for 5 minutes in rhythm with the ventilator during the expiratory phase. If a self-triggering ventilator is used, breathing exercises can also be performed.

CHEST PHYSICAL THERAPY INSTRUCTION SHEET

PATIENT: ____________________ DATE __________

DIAGNOSIS: ____________________

SEGMENTS INVOLVED: ____________________

FREQUENCY OF TREATMENT: ____________________

DOCTOR'S SIGNATURE: ____________________

SPECIFIC INSTRUCTIONS:

I. INHALATION THERAPY

A. IPPB with ____________________

for __________ minutes, followed by.

B. Aersol therapy for __________ minutes.

II. CHEST PHYSICAL THERAPY: (To follow the above)

A. Postural drainage: on the following two pages, the appropriate drainage positions for this patient will be indicated.

B. Techniques to be administered while patient is in EACH drainage position are:

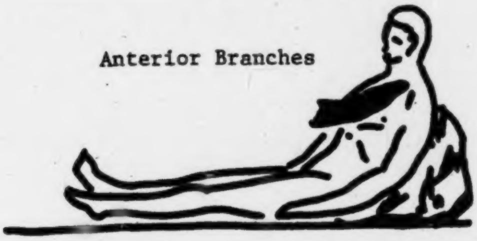
1. Percussion/Clapping, at 6 beats per second for one minute, followed by.
2. Vibrations for 4-6 expirations during deep breathing.
3. Coughing for production of mucous for approximately one minute. (Have tissues and emesis basin at hand.)
4. Repeat the procedure (steps 1-3) 5-6 times or as tolerated.
5. Remain in drainage position for approximately 15 minutes.

III. MODIFICATIONS:

POSTURAL DRAINAGE

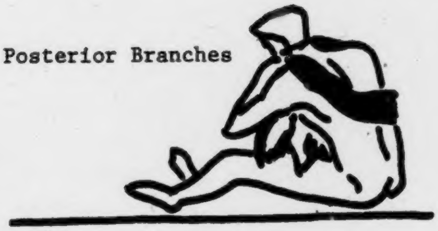
UPPER LOBES: Apical Segments

Anterior Branches



Position: leaning slightly backward.
Cup/Vibrate: over collar bone on both sides.

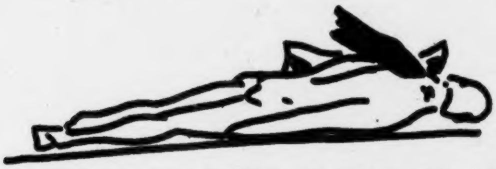
Posterior Branches



Position: leaning forward over folded pillow.
Cup/Vibrate: over shoulder on both sides.

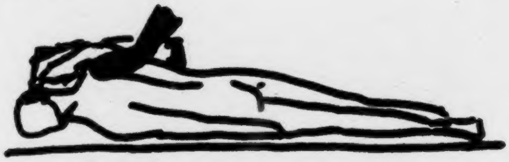
Posterior Segments

Left Upper Lobe



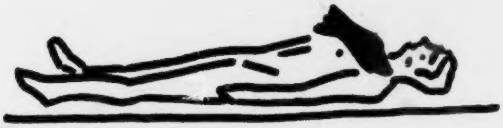
Position: turn halfway between side and stomach. On right side, support by pillow. Right arm down, left arm up.
Cup/Vibrate: over left shoulder blade.

Right Upper Lobe



Position: turn halfway between side and stomach on left side, support by pillow. Left arm down, right arm up.
Cup/Vibrate: over right shoulder blade.

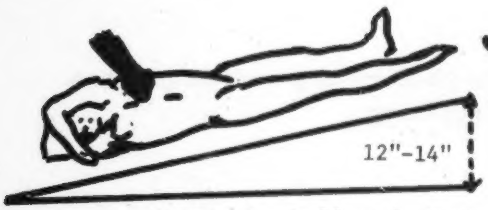
Anterior Segments
Both Upper Lobes



Position: lying flat on back.
Cup/Vibrate: between collar bone and nipple, both sides.

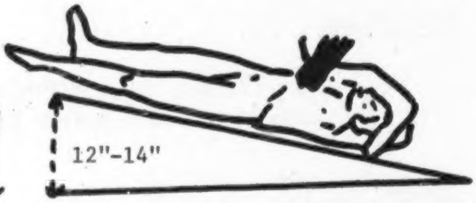
POSTURAL DRAINAGE (Continued)

Left Side, Lingular Lobe



Position: lie on right side, halfway between side and back. Support with pillow. Both arms up.
Cup/Vibrate: just below left nipple line.

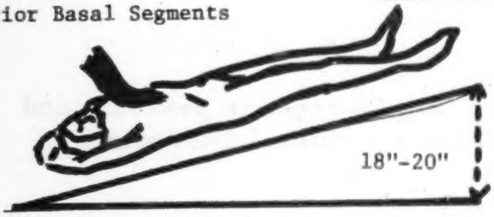
Right Side, Middle Lobe



Position: lie on left side, halfway between side and back. Support with pillow. Both arms up.
Cup/Vibrate: just below right nipple line.

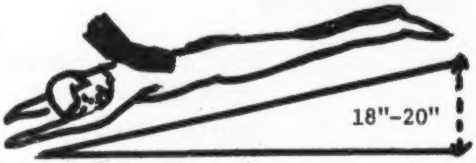
LOWER LOBES

Anterior Basal Segments



Position: lie on back, both arms up.
Cup/Vibrate: over lower ribs on front of chest.

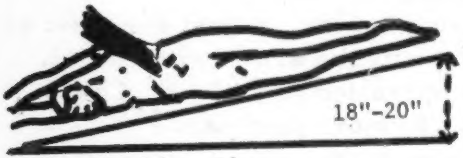
Posterior Basal Segments



Position: lie on stomach, both arms up.
Cup/Vibrate : over lower ribs on both sides of back.

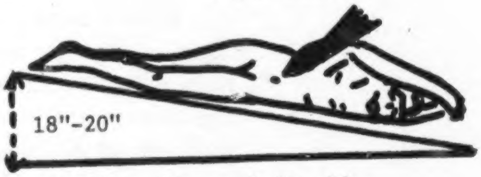
Lateral Segments

Left Side



Position: lie on right side.
Cup/Vibrate: over lower ribs on left side.

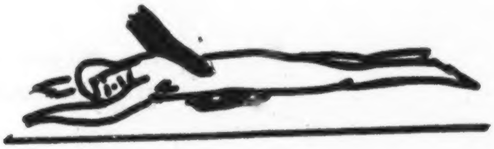
Right Side



Position: lie on left side.
Cup/Vibrate: over lower ribs on right side.

Superior Segments

Position: lying on stomach, pillow under abdomen.
Cup/Vibrate: over lower ribs on both sides of back.



PLACING PATIENT IN RESPIRATOR

(Emerson)

PURPOSE

To produce an adequate respiratory exchange when patient has difficulty breathing.

EQUIPMENT

Respirator complete with attachments and patient care pack.
Suction machine with attachments

PROCEDURE

1. Test run respirator. Adjust negative pressure and rate as ordered. Turn off motor. Test manual operation.
2. Pull out respirator cot.
    a. Cover mattress with sheet.
    b. Place one pillow case across upper end of cot. One across lower end. One across center of cot to be used as drawsheet.
    c. Place small pillow on headrest.
3. Open collar by turning to left. Adjust headrest so that pillow and cot mattress are at same level.
4. Explain respirator operation to patient. Cover patient with sheet. Remove pajamas.
5. Suction patient if necessary.
6. Place patient in respirator. Four men working together are needed.

First man at head of respirator:	Three men:
a. Give signal for lifting.	a. Use three man carry. At signal, lift patient from bed to respirator.
b. Place diaper around patient's neck.	b. Turn on motor.

PLACING PATIENT IN RESPIRATOR (Continued)

PROCEDURE (Continued)

6.

c. Give signal. Guide patient's head through collar.	c. At signal lift patient toward head of respirator, through opening.
d. Adjust headrest and cot so that patient is centered. e. Adjust collar snugly by turning ring to right. f. Suction patient if needed. g. Instruct patient to breathe "IN" and "OUT" in time with respirator, if patient is able to breathe.	d. Place patient in functional position: (1) Adjust footboard. (2) Place shoulder pads, hand, knee, ankle, and trocanter rolls as needed.

7. Watch pressure gauge:
   - a. If gauge shows drop in negative pressure, check collar, ports, gaskets and clamps for leaks.
   - b. If gauge registers positive pressure though not ordered, check to ascertain that positive pressure valve is not covered or closed. Turn knob to left to open.
8. Attach mirror to respirator. Adjust to desired angle.
9. Stay with patient. Instruct patient to swallow, talk and take fluids on expiration only.
10. Record rate, pressure, and time patient is placed in respirator. Reaction of patient. Note change of color or pulse rate.

DOME ATTACHMENT

1. Attach dome to head plate of respirator.
2. Open respirator. Slide out cot.
3. Clamp dome over patient's head.
4. Watch dome pressure gauge. Adjust pressure in dome by means of valve on inside of headplate. The pressure inside dome should be same as pressure was in respirator.

DOME ATTACHMENT (Continued)

5. To discontinue: Open and unclamp dome. Close respirator.

POINTS TO EMPHASIZE

1. Patient must be informed before any treatment is started.
2. Teamwork is essential. Each member must know his functions thoroughly.
3. Avoid overloading electrical circuit. No more than one respirator and one suction machine should be connected to a single circuit.
4. Always open and close ports when pressure gauge is at ZERO.
5. Change patient's position every two hours. Maintain alignment.

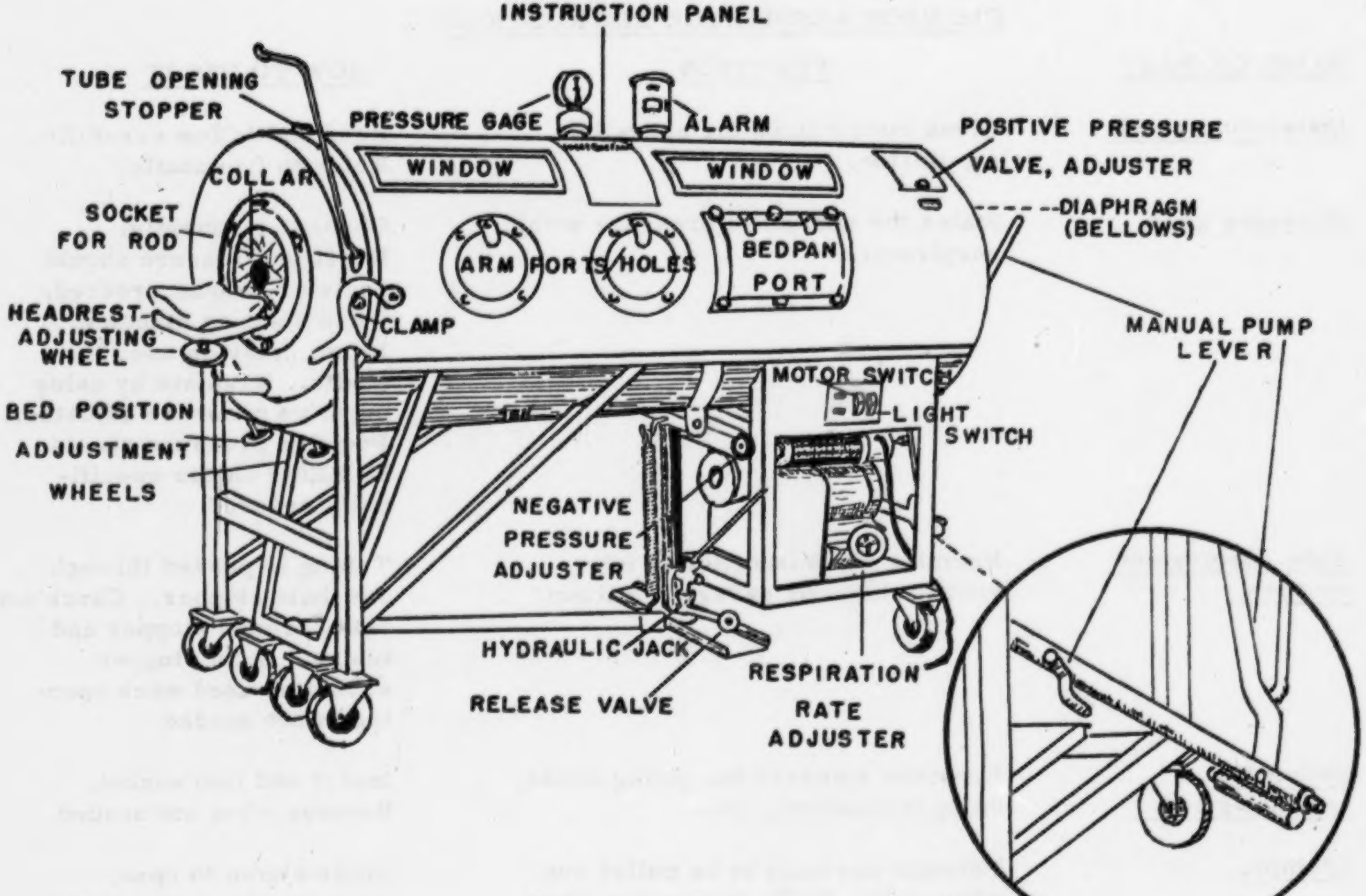
Note: Drinker-Collins Respirator

1. Follow same directions as for Emerson except:
   a. Diphragm (bellow) is located beneath respirator chamber. Bellows descend (negative pressure) and ascend (atmospheric pressure).
   b. Manual operation.
      (1) Turn off motor.
      (2) Loosen large screw just beneath bellows. Slip ring off so that bellows fall.
      (3) Insert pump handle. Tighten screw.
      (4) Move handle up and down at respiratory rate normal for patient.
      (5) To discontinue: loosen screw. Slip ring back over bar. Tighten screw. Turn on motor.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

RESPIRATOR

(EMERSON)


INSTRUCTION PANEL
TUBE OPENING STOPPER
PRESSURE GAGE
ALARM
POSITIVE PRESSURE VALVE, ADJUSTER
WINDOW
WINDOW
DIAPHRAGM (BELLOWS)
COLLAR
SOCKET FOR ROD
ARM PORTS
HOLES
BEDPAN PORT
HEADREST-ADJUSTING WHEEL
CLAMP
MANUAL PUMP LEVER
MOTOR SWITCH
LIGHT SWITCH
BED POSITION ADJUSTMENT
WHEELS
NEGATIVE PRESSURE ADJUSTER
HYDRAULIC JACK
RELEASE VALVE
RESPIRATION RATE ADJUSTER

EMERSON RESPIRATOR INSTRUCTIONS

NAME OF PART	FUNCTION	HOW TO USE IT
Instruction panel.	Gives instructions for operating respirator.	Read and follow carefully. Refer to frequently.
Pressure gage.	States the amount of pressure within respirator.	Observe frequently, Negative pressure should register amount ordered. When starting machine, 15 cm. may be used for adults. Regulate by using negative pressure adjuster. Positive pressure should be ZERO unless specifically ordered.
Tube opening and stopper.	Permits administration of intravenous fluids or gavage to patient.	Tubing is passed through one-hole stopper. Check for leaks around stopper and tubing. Solid stopper should be used when opening is not needed.
Socket for irrigating rod.	Provides standard for giving fluids, doing irrigations, etc.	Insert rod into socket. Remove when not needed.
Clamps.	Permits carriage to be pulled out when open. Seals respirator when closed.	Raise clamp to open, lower to close respirator.

EMERSON RESPIRATOR INSTRUCTIONS (Continued)

NAME OF PART	FUNCTION	HOW TO USE IT
Collar. Plastic or rubber.	Maintains desired pressure within respirator by preventing leakage around patient's neck.	Both collars. Place padding around patient's neck before adjusting. Plastic. Turn to left to open. Patient's head is drawn through opening of respirator. Collar ring is turned to right until it fits snugly around patient's neck. Tighten wing nuts.
Tracheotomy bar.	Tracheotomy bar is used with plastic collar to permit more working area around patient's neck.	Place tracheotomy bar over posts at each side of collar ring. Tighten wing nuts. Sponge rubber. Carry ends of 5 straps through opening and attach to posts on outside of respirator. Patient's head is drawn through collar. Start with back and end with top strap. Gently release each strap until collar fits snugly around patient's neck.
Headrest. Wheels for adjusting.	Raises and lowers patient's head.	Turn wheel to left to raise, to right to lower.

EMERSON RESPIRATOR INSTRUCTIONS (Continued)

NAME OF PART	FUNCTION	HOW TO USE IT
Bed position adjustment wheels.	Raises, lowers and tilts respirator cot to either side.	Turn wheels together in same direction; to right to lower, to left to raise. Turn wheels in opposite direction to tilt cot to either side.
Hydraulic jack, release valve, (Cotter pin in older models.	Tilts entire respirator into shock position to promote drainage.	Close release valve by turning to right. (Use end of jack handle for older models.) Insert handle into socket and pump until respirator is tilted to desired angle. To lower, turn release valve VERY SLOWLY to left.
Negative pressure adjuster.	Increases and decreases negative pressure within respirator. (Controls depth of respiration).	To decrease pressure, turn knob to left. To increase, turn to right.
Respiratory rate adjuster.	Increases and decreases number of respirations a minute.	To decrease rate, turn to left; to increase, turn to right.

EMERSON RESPIRATOR INSTRUCTIONS (Continued)

NAME OF PART	FUNCTION	HOW TO USE IT
Motor switch. Plug on cord should be grounded and of lock type.	Operates respirator electrically. AC current.	Motor requires 5-6 amperes to start. Load on circuit should be checked before use. Know where fuse box or circuit breaker is located. When patient is in respirator, cover switch with tape to avoid turning off motor accidentally. The AC-DC box is set by engineer... DO NOT TAMPER WITH THIS box.
Light switch.	Illuminates interior of respirator.	Avoid using or leaving on more than necessary. Generates heat within respirator.
Diphragm (bellows)	Moves in and out, thereby alternating negative and atmospheric pressure.	Operates automatically after being set.
Manual pump, lever.	Operates respirator manually when motor is off or power fails.	Flip lever on connecting rod up and down toward floor as far as it will go. Turn off motor switch. Grasp pump handle with both hands, sway back and forth at about the same rate as the patient has

EMERSON RESPIRATOR INSTRUCTIONS (Continued)

NAME OF PART	FUNCTION	HOW TO USE IT
Manual pump, lever. (Continued)	Operates respirator manually when motor is off or power fails.	been breathing. Turn pressure gage toward operator. To discontinue: Flip lever up toward machine and back as far as it will go. Move pump handle until a "click" is heard. Turn on motor.
Positive pressure valve and adjuster.	Increases pressure within respirator above atmospheric pressure.	Should normally be open. IS RARELY USED: If positive pressure is ordered; turn knob to right, watch pressure gage.
Windows.	Permits observation of patient in respirator.	Wash with clear water. Do not use alcohol.
Bedpan port/door.	Permits placing articles within respirator.	Have articles close at hand. Turn clamps up. Watch pressure gage, at ZERO quickly open door and insert articles. Close door immediately, turn clamps down.

EMERSON RESPIRATOR INSTRUCTIONS (Continued)

NAME OF PART	FUNCTION	HOW TO USE IT
Arm Port holes.	Permits giving patient care in respirator.	Turn clamp on arm port up. At ZERO on pressure gage, open door, thrust arms through openings in rubber discs. When care is completed, watch pressure gage, at ZERO, quickly take out arms. Close door, turn clamps down.
Alarm.	Warns when motor has stopped or pressure has fallen below 10 cm. negative pressure.	Battery operated. Switch should be "ON" at all times when patient is in respirator. If motor has stopped - start manual operation... call for assistance to check wall plug, fuse box or circuit breaker. If negative pressure has fallen check collar, port holes, clamps, tube opening for leaks.

EMERSON RESPIRATOR INSTRUCTIONS (Continued)

Test Run Respirator

1. Tighten knobs on all port gaskets
2. Twist collar to right until closed.
3. Tighten wing nuts. Start motor.
4. Increase neg. pressure to 35 cm. Check for leaks.
5. Increase then decrease respiratory rate. Time with watch to check response to adjustment.
6. Turn off motor.
7. Test manual operation. Follow above.

Preventive Maintenance

1. Test run respirator weekly. Loosen gasket knobs and open collar after test.
2. Check condition of sponge rubber collar or gaskets on ports and sealing gasket at headplate of respirator. Dry, crumbling sponge should be replaced. Sealing gasket that is sticky, uneven and gouged should be replaced. (Engineer.)
3. Check condition of plastic collar. Hard, stiff or brittle collar should be replaced.
4. Motor is responsibility of engineer but a maintenance check card should be attached to each respirator. Note last date on card.
5. Check that all attachments are with machine-mirror, wing nuts, tracheotomy bar, footboard, jack handle, spare motor belt, adapter for two prong plug.
6. Check that patient care pack is complete and in respirator.
7. Place dust cover over respirator.

Patient Care Pack

Materials needed to initially place patient in respirator.
In pillowcase: (Plastic recommended)
Sheet for mattress cover
3 pillow cases
4 diapers folded diagonally to 3 inch width for collar pads
2 sponge rubber pads 4"x6"x1", covered with diaper for shoulder pads
2 rolls cotton wadding for hand and ankle supports
2 pieces stockinette, 2" wide x 12" long
2 safety pins
2 covered sandbags for trochantar rolls
Small pillow with cover
Diaper or baby blanket for patient cover
Folded bath towel

COUGH PROCEDURE FOR PATIENT IN RESPIRATOR

PURPOSE

To facilitate drainage of lungs.

Note: This procedure utilizes the negative pressure adjuster on the respirator. The pressure and number of coughs are ordered by the medical officer.

An intermittent positive pressure treatment using a wetting agent medication is usually given 30 minutes before this procedure. In this half hour waiting period, the patient is tilted with the respirator. Ten minutes to the left. Ten minutes to the right. Ten minutes in Trendelenberg.

PROCEDURE

1. Explain procedure and tell patient what he is to do.
2. Suction patient. Check collar, shoulder pads and patient's position.
3. Turn negative pressure adjuster to right until prescribed pressure is reached.
4. Open bedpan port quickly. Allow port to remain open for one complete "in" and "out" cycle of respirator bellows. Close port.
5. Repeat steps 3 and 4 for 6 coughs.
6. Return negative pressure to normal for patient. Turn adjuster to left.
7. Allow three minutes rest period. Suction patient. Check collar, patient's position, shoulder pads.
8. Repeat steps 3 through 8 as prescribed by medical officer.

POINTS TO EMPHASIZE

1. Lock wheels of respirator.
2. Suction patient before and after each series of coughs.
3. Check that collar is still secured to metal rings.

COUGH PROCEDURE FOR PATIENT IN RESPIRATOR (Continued)

POINTS TO EMPHASIZE (Continued)

4. **Open bedpan port quickly. It is the sudden, abrupt change of pressure which causes the patient to cough.**
5. **Check patient for signs of exhaustion or complaints of pain.**

ADDITIONAL INFORMATION FOR THIS ACTIVITY

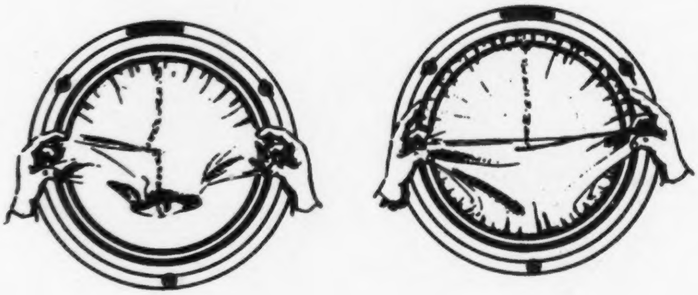
PLACING PATIENT IN RESPIRATOR
(Spiratwist)

PURPOSE

To maintain an airtight seal about the patient's neck while in a respirator.

EQUIPMENT

Plastic collar



PROCEDURE

1. Lock collar by tightening wing nuts.
2. Stretch small end of plastic tube over metal inner ring, seam at top. Tuck securely behind rubber stripping.
3. Start opposite end of same seam on outer ring, exactly covering small end seam. Stretch completely around outer ring, behind rubber stripping.
4. Loosen wing nuts. Twist collar to proper size. Tighten wing nuts.

REPLACING PLASTIC COLLAR ON RESPIRATOR (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PORTABLE RESPIRATOR

(Monaghan)

PURPOSE

To produce and maintain adequate respiration.

EQUIPMENT

Portable Respirator with Hand Bellows Resuscitator
Power Unit
Battery Unit and Battery Charger
T-shirt
Shells with straps

PROCEDURE

Single Operation

1. Read instructions on case.
2. Turn switch on.
3. Turn: Rate Control Knob to "3"
   "NEG" Control Knob to "6"
   "POS" Control Knob to "1"
4. Connect hose to respirator:
   - a. Insert the straight metal end of large hose into airport located in center back of case.
   - b. Insert small hose attachment into airport at right of large airport.
   - c. Tell patient what you are going to do and what he is to do and why.
5. Slip patient into a T-shirt.
6. Select largest shell which will fit patient.
7. Connect hose to shell by inserting the elbow end into the fitting lock with a twisting motion but with very little force.
8. Apply shell to patient with rubber sealing element deflated.
   - a. From collar bone to lower abdominal area in front.
   - b. From slightly below shoulder blade to upper hip region in back.
   - c. From center of armpit to hip at sides.

PORTABLE RESPIRATOR (Continued)

(Monaghan)

PROCEDURE (Continued)

9. Apply straps:
    a. Select two straps:
        (1) One same size as shell for upper hooks.
        (2) One next smaller size for lower hooks.
    b. Place straps under patient's back with humped sides of buckles up.
    c. Attach buckles to hooks on each side of shell.
10. Check for leaks between shell and patient. If present:
    a. Screw hand bulb into valve on seal.
    b. Turn valve to left.
    c. Squeeze bulb few times - Do Not Over Inflate.
    d. Turn valve to right to disconnect.

Battery Operation

1. Connect battery to power unit which may or may not be connected to the house current.
2. Insert the four-hole plug WITH WHITE LINE UP, into the four-pronged socket located in center back of power unit case.
3. Turn switch on.

Manual Operation - Hand Bellows Resuscitator

1. Remove mask assembly from case.
2. Attach bellows.
3. Place mask over patient's face. Hold chin firmly up and forward.
4. Open and close bellows rhythmically at the same rate patient has been breathing.

POINTS TO EMPHASIZE

1. The respirator operating on electrical current should have the battery unit attached so battery will automatically function if power fails.
2. The small white line of the four-hole plug must point up to connect battery to power unit.
3. The indicator light will remain lit as long as the machine is on battery operation.

PORTABLE RESPIRATOR (Continued)
(Monaghan)

CARE OF EQUIPMENT

1. Wash shell(s) and face mask with warm soapy water. Rinse, dry.
2. Use disinfectant solution prescribed locally. Do Not use alcohol or formaldehyde.
3. Store shells, hose, straps and hand bulb in original case:
    a. Store shells with rubber cushion Up.
    b. Do not place in sunlight, near heat or autoclave.
4. Written schedules should be kept for charging battery and maintenance checks:
    a. Plug battery into house current for four hours.
    b. Indicator balls will float on top of liquid when fully charged.
    c. Always use Distilled water to maintain fluid level in battery.

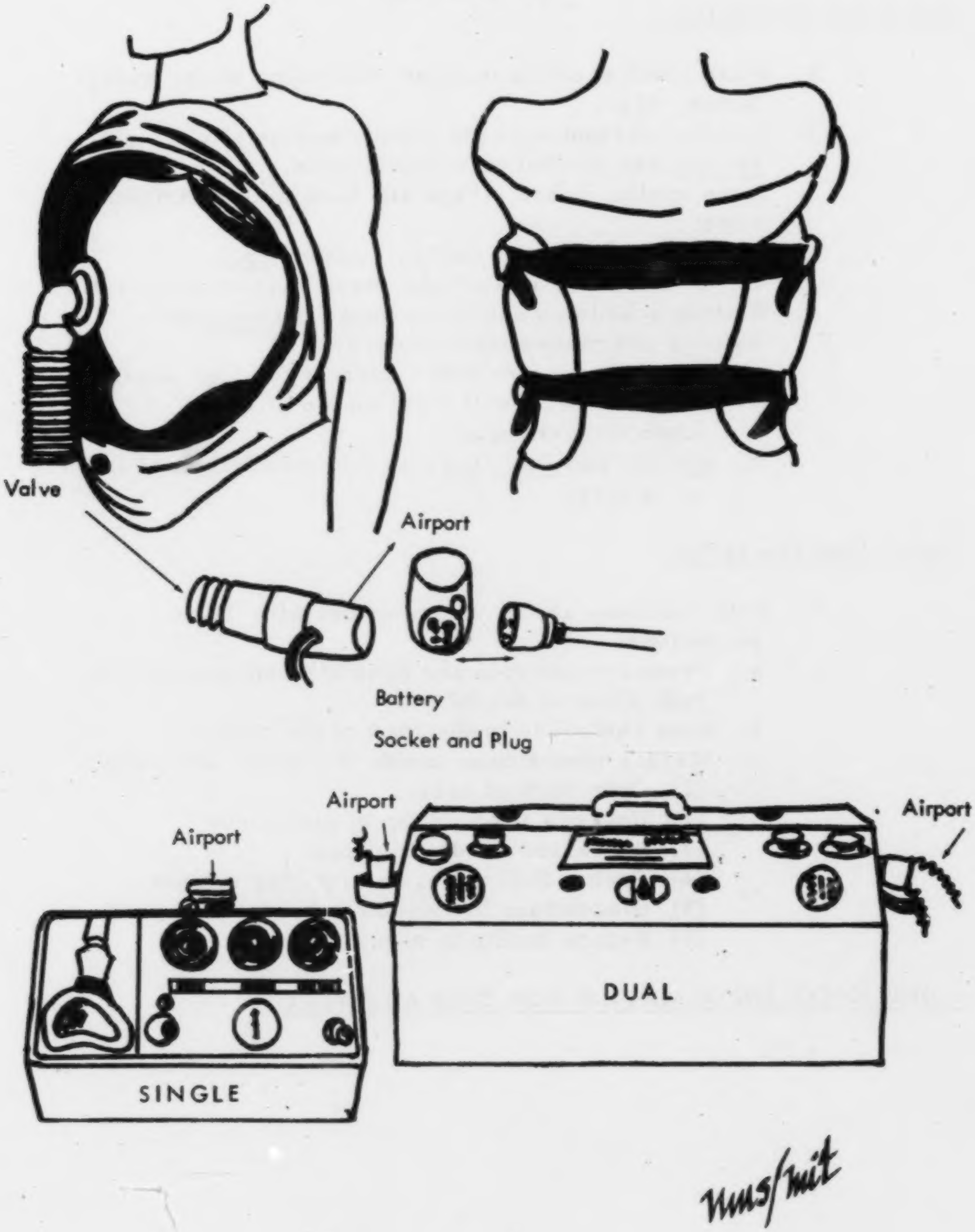
Note: Dual Operation.

1. This functions as the single model with these exceptions:
    a. Pressure controls and hose attachments are on both sides of the case.
    b. Rate control is in the back of the case.
    c. Manual operation is inside the power unit case:
        (1) Open back of case.
        (2) Unscrew knob on top of piston rod.
        (3) Screw red handle in place.
        (4) Push - Pull at normal rate for patient.
        (5) Discontinue by replacing handle with knob.
        (6) Return handle to slip.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PORTABLE RESPIRATOR

(Monaghan)


Valve
Airport
Battery
Socket and Plug
Airport
Airport
Airport
SINGLE
DUAL

nms/mit

OSCILLATING (ROCKING) BED

(Emerson)

PURPOSE

To aid circulation in peripheral vascular disease.
To promote body metabolism.

EQUIPMENT

Oscillating bed
Footboard
Padded shoulder supports
Knee, ankle and hand rolls as needed
Safety three prong electrical plug, ground wire or drag chain

PROCEDURE

1. Read instructions attached to bed just below switch.
2. Attach ground wire if used. Turn on motor.
3. Adjust bed to oscillate (rock) at rate of speed and angle ordered. Turn off motor when bed is horizontal and head of bed is rising.
4. Explain bed operation to patient.
5. Place patient on bed in anatomical alignment. Head and knee gatch of bed may be used.
6. Adjust footboard, shoulder pads, and rolls.
7. Start motor. Hold patient's hand or place your hand on his shoulder for reassurance. Instruct patient to breathe with machine.

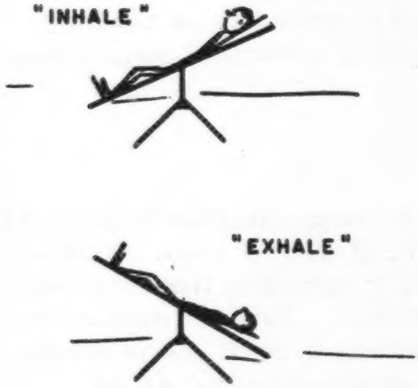
POINTS TO EMPHASIZE

1. Place patient on bed at least an hour before meals when possible.
2. Stay with patient until he is accustomed to bed. Check him frequently.
3. Place call bell within reach.
4. Instruct patient to breathe with machine.
5. When necessary to stop bed - Wait until bed is in horizontal position.

OSCILLATING (ROCKING) BED (Continued)

CARE OF EQUIPMENT

1. Have bed checked:
    - a. Before putting into operation.
    - b. Weekly if in prolonged use.
    - c. Before placing in storage.



BREATHING WHILE ON OSCILLATING BED

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CENTRAL VENOUS PRESSURE

PURPOSE

To measure the venous pressure in the vena cava or the heart's right atrium.

EQUIPMENT

Skin prep antiseptic solution
Sterile towels
Sterile gloves (for the doctor)
Local anesthetic solution and equipment
Sterile large bore needle and I.V. catheter
Sterile 5 or 10 cc syringe
Sterile I.V. extension tubing
Sterile water manometer
Sterile 3-way stopcock
Sterile dressing
Adhesive tape
I.V. setup (with ordered fluid)
I.V. standard

PROCEDURE

1. Wash hands. Explain procedure to patient.
2. Assist doctor with venesection and/or insertion of large-bore needle with an enclosed cannula.
3. After insertion, the cannula is removed.
4. The doctor advances the catheter through the needle into the superior vena cava or the right atrium.
5. The needle is removed and the catheter is attached via extension I.V. tubing to one side of a 3-way stopcock. Extending upward from the center of the stopcock is a glass manometer. Regular I.V. tubing and solution is connected to the remaining side of the stopcock.
6. After the apparatus has been assembled and the I.V. flow started the doctor will do the initial C.V.P. measurement. Subsequent measurements are done by the nurse and/or corpsman.
7. Measurements are made by turning the stopcock from the flow position so that it directs the solution away from the patient and into the manometer.
8. When the manometer level reaches 30 cm., turn the stopcock to allow the column of fluid to flow to the patient. (After 15 to 20 seconds, the fluid reaches a level equal to the patient's central venous pressure and the column ceases to descend. A rhythmic rise and fall, usually 1 to 2 cm., occurs at the top of the column reflecting the patient's respiration. The high point of the rise is read as the patient's C.V.P.).

CENTRAL VENOUS PRESSURE (Continued)

PROCEDURE (Continued)

9. Turn stopcock back to flow position and infusion will continue at rate ordered by the doctor.
10. Record C.V.P. on plotting chart.

POINTS TO EMPHASIZE

1. Positioning of patient and manometer are crucial for accurate C.V.P. measurement: the patient lies supine and quiet with the head of the bed flat. The manometer is set so that the zero mark lies at the level of the mid-axillary line (level of the right atrium.)
2. Initial positioning and C.V.P. measurement is done by the doctor.
3. Notify the doctor of any unusual readings below or above the normal range of 5-12 cm. of water pressure, or a sudden rise or fall from the patient's usual reading.
4. Close observation of catheter site is necessary to prevent hematoma and phlebitis.
5. Keep tubing free of kinks or any other obstruction.
6. Intervals of C.V.P. measurement and methods of recording are determined by local instructions.

CARE OF EQUIPMENT

1. Discard disposable items.
2. Wash and rinse other equipment and return to CSR.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TOURNIQUETS IN PULMONARY EDEMA

(Bloodless Phlebotomy)

PURPOSE

To slow down peripheral circulation thus reducing the strain and volume of blood to the heart and lungs.

EQUIPMENT

Four tourniquets or
Four blood pressure cuffs with gauges

PROCEDURE

1. Inform patient in advance as to the nature and general purpose of procedure, if condition permits.
2. Place tourniquets under each extremity, as high as possible.
   a. Under each leg just below the groin.
   b. Under each arm just below axilla.
3. Check arterial pulse in each extremity.
4. Tighten tourniquets, except that under left arm, by means of slip knots.
5. Recheck arterial pulses to be sure they have not been obliterated.
6. Watch clock. Wait for specified time interval.
7. Continue tightening tourniquets clockwise as follows:
   a. Tighten tourniquet on left arm and release tourniquet on left leg. Wait time interval.
   b. Tighten tourniquet on left leg and release tourniquet on right leg. Wait time interval.
   c. Tighten tourniquet on right leg and release tourniquet on right arm. Wait time interval.
8. Repeat steps 2 through 6 until discontinued.
9. Discontinue by removing one tourniquet at a time. Maintain original order of sequence and time interval until all are removed.
10. Charting - include direction and time interval tourniquets applied and released.

TOURNIQUETS IN PULMONARY EDEMA (Continued)

POINTS TO EMPHASIZE

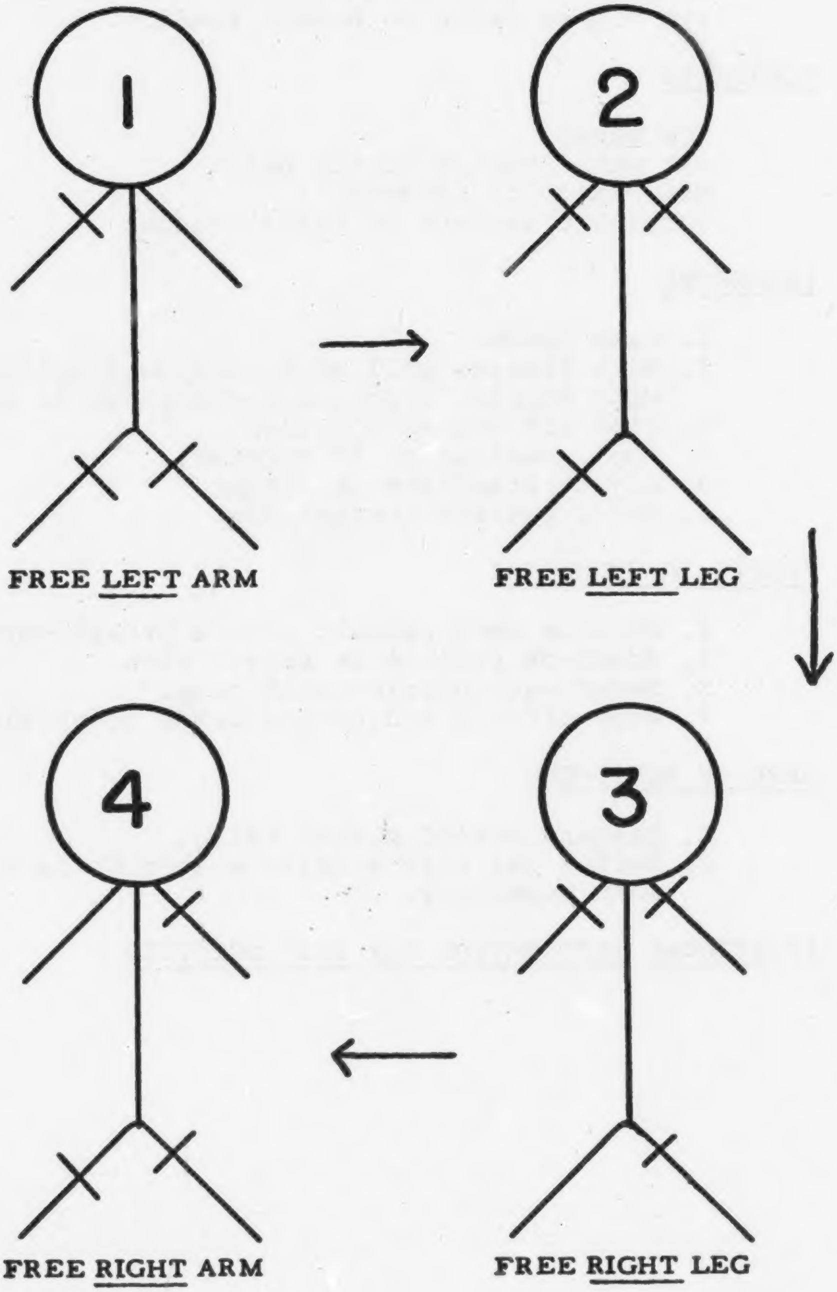
1. Follow written orders concerning time intervals for tightening tourniquets.
2. Adopt a system of rotation for releasing and tightening tourniquets. Always proceed in the same direction whether clockwise or counter clockwise.
3. Apply tension that will not obliterate arterial pulse. Obliteration of pulse means that tourniquets are too tight.
4. Follow original order and time interval when discontinuing procedure. Removal of all tourniquets at one time will release too much blood and cause strain to the heart.

CARE OF EQUIPMENT

1. Wash and dry tourniquets.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ROTATION OF TOURNIQUETS


1
2
3
4
FREE LEFT ARM
FREE LEFT LEG
FREE RIGHT LEG
FREE RIGHT ARM

BREAST CARE

PURPOSE

To prevent skin irritation of the breast, and to cleanse the nipple prior to breast feeding.

EQUIPMENT

Tap water
Jar with sterile cotton balls
Medication if ordered
Nursing brassiere or breast binder

PROCEDURE

1. Wash hands.
2. Wash breasts well with moistened cotton ball, starting with nipple first and working out in circular motion.
3. Wipe off excess solution.
4. Apply medication if ordered.
5. Adjust brassiere or binder.
6. Leave patient comfortable.

POINTS TO EMPHASIZE

1. Provide each patient with a breast care tray.
2. Instruct patient in breast care.
3. Never wash nipples with soap.
4. Wipe off all medication prior to nursing.

CARE OF EQUIPMENT

1. Discard soiled cotton balls.
2. Refill jar with sterile cotton balls and tap water when necessary.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PERINEAL CARE

PURPOSE

To cleanse perineal area.
To promote healing of the perineum.
To teach patient principles of personal hygiene.

EQUIPMENT

Disposable Tray or -
Tray with:
    Sterile pitcher of warm tap water
    Sterile perineal pads
    Sterile cotton balls
Bedpan and cover
Disposable sanitary napkin bag
Sanitary belt or T binder

PROCEDURE

1. Wash hands.
2. Screen patient and tell her what you are going to do.
3. Remove perineal pad from front to back. Note drainage. Place in sanitary napkin bag at foot of bed.
4. Place patient on bedpan.
5. After patient has voided:
    a. Have patient flex her knees.
    b. Turn covers down to knees.
    c. Pour solution over vulva from above downward.
    d. With cotton ball, dry labia with one downward stroke. Discard cotton in sanitary napkin bag. Repeat.
    e. Remove bedpan. Have patient turn on her side.
    f. Dry anal region from front to back with cotton ball.
    g. Apply sterile perineal pad from front to back. Secure with sanitary belt or T binder.
    h. Remove equipment. Leave patient comfortable.

POINTS TO EMPHASIZE

1. Test temperature of water by pouring a little over wrist.
2. Use only ONE downward stroke front to back with EACH cotton ball. Discard.
3. Avoid touching side of pad that comes in contact with patient.
4. Patients may go to bathroom to give self care after being taught this procedure.

PERINEAL CARE (Continued)

CARE OF EQUIPMENT

1. Discard sanitary napkin bag.
2. Reset tray.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PERINEAL LIGHT

PURPOSE

To promote healing of the perineum.

EQUIPMENT

Lamp with 40 watt bulb
Sterile perineal pad
Disposable sanitary napkin bag

PROCEDURE

1. Wash hands.
2. Screen patient and tell her what you are going to do.
3. Place patient in dorsal recumbent position.
4. Drape patient with top sheet.
5. Unfasten sanitary belt or binder.
6. Remove pad. Place in sanitary napkin bag. Discard. Place a clean one under patient.
7. Position light so heat is directed toward perineum.
8. After treatment, replace perineal pad, straighten bedding and leave patient comfortable.

POINTS TO EMPHASIZE

1. Place lamp no closer than 18 inches so as not to burn the patient or the bedding.
2. Check patient frequently.
3. Duration of treatment should not exceed 20 minutes.

CARE OF EQUIPMENT

Wipe lamp with cloth dampened with disinfectant before using the lamp for another patient.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

INFANT INCUBATOR

(Armstrong)

PURPOSE

To provide a warm and safe environment for infants.

EQUIPMENT

Infant incubator (Armstrong) with stand
Mattress with cover
Ground wire, safety plug or drag chain
Distilled water

PROCEDURE

1. Fill tray three-fourths full with distilled water. Place tray over heating unit.
2. Close top and bottom ventilators.
3. Close incubator lid.
4. Plug in electric cord. Green pilot light will go on.
5. Turn heat control dial to start.
6. Watch thermometer. When required temperature is reached, turn control dial to right until red light goes out; then turn slowly to the left until red light comes on.
7. Adjust humidity by following instruction printed on top lid of incubator.
8. Lock wheels of stand. Incubator is now ready for infant.
9. Open ventilators prior to placing infant in incubator.

POINTS TO EMPHASIZE

1. Water tray should always be three fourths full when in use. Add distilled water every 6 - 8 hours as necessary.
2. Green pilot always glows when incubator is on. If it goes out, check wall plug, power, light bulb.
3. Once the incubator is set at a desired temperature, it will maintain automatically.

INFANT INCUBATOR (Continued)

(Armstrong)

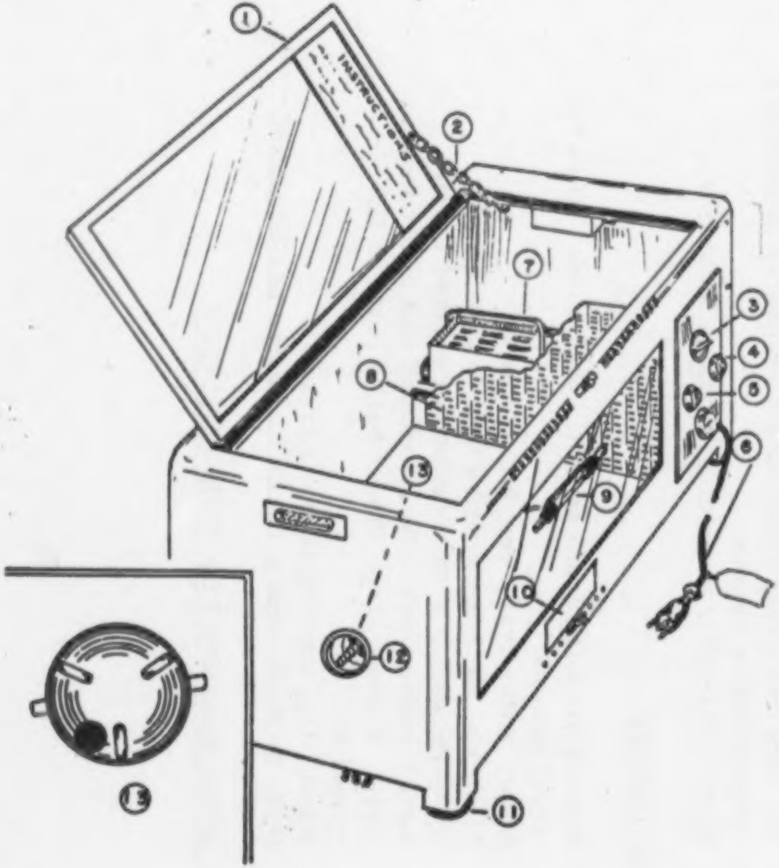
POINTS TO EMPHASIZE (Continued)

4. Always regulate incubator temperature by thermometer reading.
5. Do not place towels or other materials under the incubator. The conductive rubber legs must be in constant contact with aluminum shelf of incubator stand.
6. Use only explosion proof model incubator in delivery and operating rooms.
7. Open vents prior to placing infant in incubator.

CARE OF EQUIPMENT

1. Disconnect cord from socket. Coil cord. Store on shelf of stand.
2. Empty water tray, remove mattress.
3. Allow one hour for heating unit to cool off.
4. Wash incubator with solution prescribed locally.
5. Lower baffle plate. Wash around and under heating unit. Rinse. Dry. Reset baffle plate in UP position.
6. Wash, dry, and replace mattress.
7. Have medical repair check incubator periodically.

ADDITIONAL INFORMATION FOR THIS ACTIVITY



① Instruction Panel
② Chain Support
③ Heat Control Dial
④ Green Pilot Light
⑤ Red Pilot Light
⑥ Service cord, 3 prong plug
⑦ Water Tray
⑧ Baffle Plate
⑨ Dry Bulb Thermometer
⑩ Top and Bottom Ventilators
⑪ Conductive Rubber Foot
⑫ Oxygen Nipple
⑬ Diffusion Shield (inside incubator opposite 12.)

INFANT INCUBATOR

(Isolette)

PURPOSE

To provide an environment of controlled temperature, humidity and oxygen for newborn and small infants.

EQUIPMENT

Isolette
Mattress with protective cover
Linen as needed
Distilled water

For Oxygen Add:

Oxygen supply
Oxygen gauge
Four feet of rubber tubing
Non-magnetic wrench
"No Smoking" signs
Mechanical oxygen analyzer

For Cooling Add:

Cracked ice
Tap water

PROCEDURE

1. Make up Isolette.
2. Close hood and porthole sleeves.
3. Fill humidity chamber with distilled water.
4. Connect unit to electrical circuit.
5. Set control handle for desired humidity.
6. Turn heat control knob to the left to raise temperature inside isolette. Heater light will go on.
7. Allow one hour, if possible, to preheat Isolette.
8. Turn heat control knob to the right just enough to turn off heater light, when desired temperature has been reached.

INFANT INCUBATOR (Continued)

PROCEDURE (Continued)

9. Raise hood and place infant in Isolette.
10. Lower hood.

For Oxygen

1. Connect gauge and rubber tubing to oxygen.
2. Attach other end of tubing to oxygen nipple on Isolette.
3. Turn on oxygen and adjust flow to desired amount.
4. Check oxygen concentration with mechanical analyzer.

Cooling Isolette

1. Cool Isolette only when ordered.
2. Fill cooling chamber with ice.
3. Add about one quart water.
4. Set heat control knob at minimum temperature ordered.
5. Turn humidity control knob to FULL.
6. Drain ice chamber by small petcock at base.

Elevating Deck at Head or Foot

1. Insert arms through portholes.
2. Lift either end of deck. Hook over plastic baffle.

POINTS TO EMPHASIZE

1. Carry out procedures through portholes.
2. Maintain constant temperature and humidity.
3. Avoid placing Isolette in direct sunlight or near radiator. Red light and alarm buzzer will go on if Isolette becomes overheated.
4. Always refer to thermometer mounted inside Isolette hood.
5. Before putting infant in Isolette who has had ether, preheat unit to desired temperature, then turn off completely. The heat should not be turned on again until all residual ether has disappeared. This usually takes 2 hours.

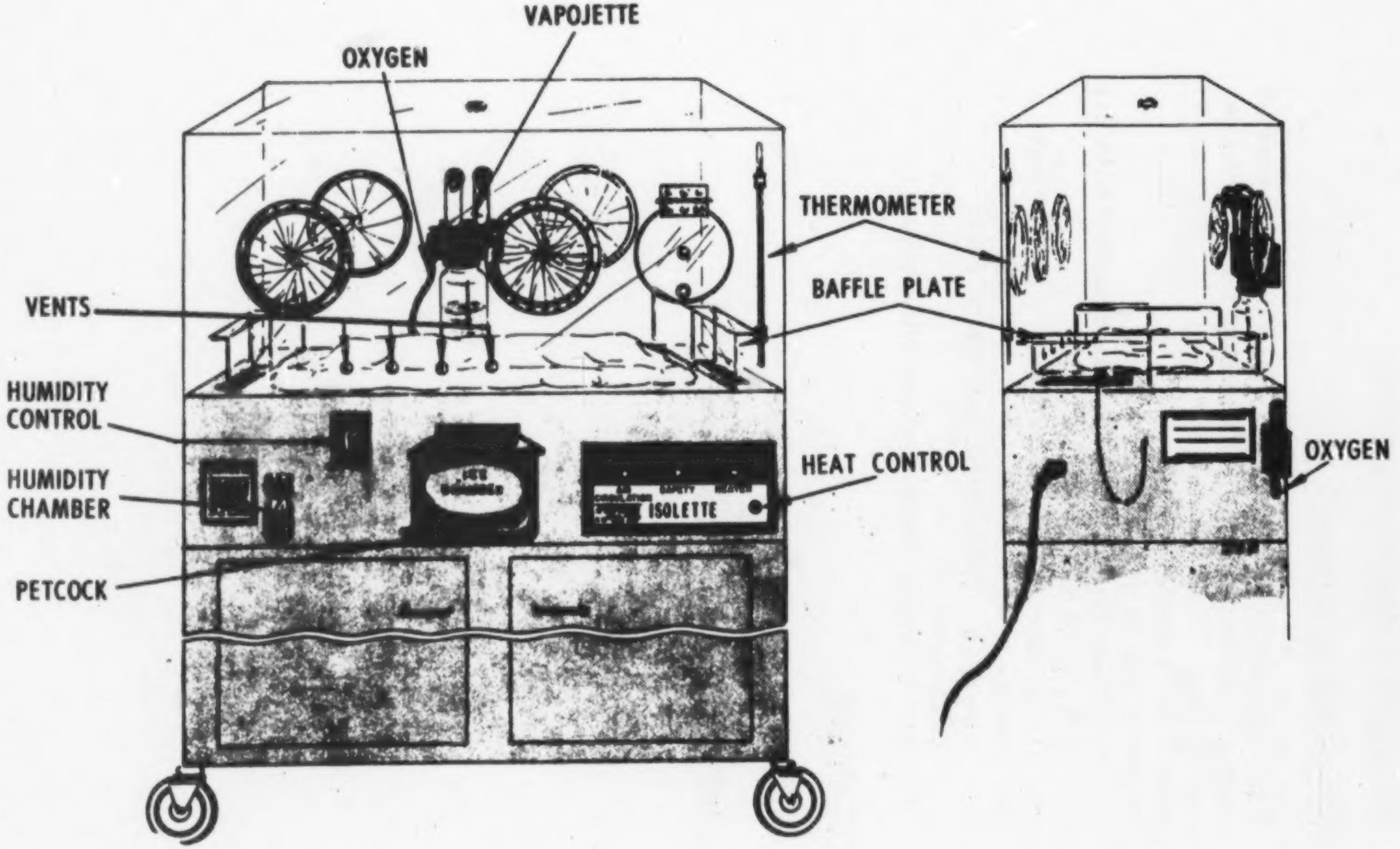
POINTS TO EMPHASIZE (Continued)

6. Keep humidity chamber filled with distilled water so water level is always visible through glass window in fill pipe.
7. Never close vents.
8. When oxygen is used:
    a. Maintain same precautions as required with any oxygen administration.
    b. Do not use gauge with humidifier attachment.
    c. Change microfilm pad every 30 days, if so equipped. (Microfilm pad inside inlet connection.)
    d. Check oxygen concentration with analyzer.

CARE OF EQUIPMENT

Wash Isolette thoroughly after each use.

ADDITIONAL INFORMATION FOR THIS ACTIVITY


VAPOJETTE
OXYGEN
THERMOMETER
BAFFLE PLATE
VENTS
HUMIDITY CONTROL
HUMIDITY CHAMBER
HEAT CONTROL
ISOLETTE
PETCOCK
OXYGEN

VAPORIZER - INCUBATOR

(Vapojette-Isolette)

PURPOSE

To provide aerosol therapy in an Isolette.

EQUIPMENT

Isolette
Oxygen supply
Oxygen gauge
Four feet of rubber tubing
Non-magnetic wrench
"No Smoking" signs
Mechanical oxygen analyzer
Distilled water or prescribed medication

With Compressed Air

Compressor pump

PROCEDURE

1. Unscrew jar from vaporizing unit. Fill with distilled water. Replace.
2. Mount unit in twin vent holes on back of Isolette hood.

With Oxygen

1. Set oxygen gauge at 6 liters, or as ordered.
2. Attach oxygen tubing directly from gauge to Vapojette nipple.
3. Check oxygen concentration with analyzer.

With Compressor

1. Attach tubing from compressor to Vapojette nipples.
2. Connect pump to electrical circuit.
3. Operate pump at 6-8 lbs. pressure.

VAPORIZER - INCUBATOR (Continued)

(Vapojette-Isolette)

POINTS TO EMPHASIZE

1. Use same PRECAUTIONS as required with any oxygen administration.
2. Keep water jar filled with distilled water.
3. Certain ingredients contained in aerosol preparations damage metal, rubber and paint. Clean Isolette thoroughly after use.

CARE OF EQUIPMENT

1. Discontinue flow of oxygen, or disconnect pump from electrical circuit.
2. Empty vaporizer jar. Rinse, dry and replace.
3. Clean Vapojette atomizer:
    a. Grasp knurled shaft firmly, and pull out entire atomizer with a twisting motion.
    b. Clean atomizing tip under running water, using small brush.
    c. Replace by moistening black sealing rings with water. Insert with twisting motion.
    d. Push atomizing unit up as far as it will go.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ISOLETTE ROCKER

PURPOSE

To aid respiration and promote drainage from the respiratory tract in premature infants.

EQUIPMENT

Isolette
Cylinder oxygen or compressed air
Oxygen gauge
Non-magnetic wrench
"No Smoking" signs
Distilled water
Isolette rocker with pressure regulator and tubing
Special diaper

PROCEDURE

1. Attach oxygen gauge, and pressure regulator with tubing to cylinder. Use non-magnetic wrench.
2. Place and secure cylinder next to Isolette.
3. Fill humidity chamber with distilled water.
4. Open hood of Isolette. Remove mattress and top deck.
5. Mount rocker in Isolette. Cover rocker pad.
6. Place and secure positioning rod horizontally.
7. Pass rubber and plastic tubing through rear porthole of Isolette.
    a. Connect rubber tube to pressure regulator hose.
    b. Allow plastic tube to hang free.
8. Turn on oxygen to 3-4 liters. This will set rocker in motion.
9. Regulate angle and rate of rocking by adjusting knobs located on side of rocker.
10. Stop rocker by turning off oxygen.
11. Place rocker in horizontal position. Lock rod in vertical position.
12. Fasten special diaper to rocker at each side and at foot.
13. Place infant in diaper. Adjust shoulder cushions.

ISOLETTE ROCKER (Continued)

PROCEDURE (Continued)

14. Turn on oxygen.
15. Release rod. Lock in horizontal position.
16. Close hood and portholes.

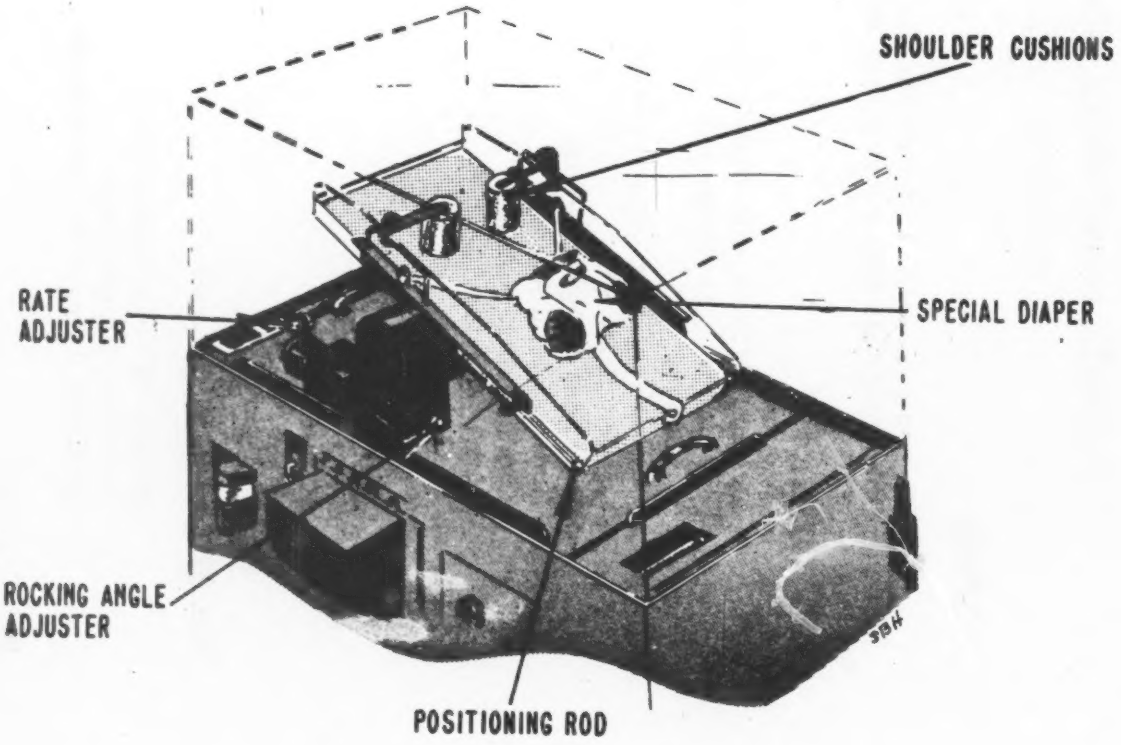
POINTS TO EMPHASIZE

1. Use same precautions as required with any oxygen administration.
2. Be sure infant is in special diaper.
3. Carry out procedures through portholes.

CARE OF EQUIPMENT

1. Label special diapers for separate laundering.
2. Disconnect rubber tubing from pressure regulator hose.
3. Draw both tubes into Isolette through rear porthole.
4. Wipe rocker and tubes with damp cloth. Remove from Isolette.
5. Wash Isolette in usual manner.
6. Set up unit.
7. Leave Isolette complete with rocker, diapers and oxygen equipment, ready for use.

ADDITIONAL INFORMATION FOR THIS ACTIVITY


SHOULDER CUSHIONS
RATE ADJUSTER
SPECIAL DIAPER
ROCKING ANGLE ADJUSTER
POSITIONING ROD
SBH

HUMIDITY AND OXYGEN THERAPY

(Croupette)

PURPOSE

To provide a cool environment high in humidity and supplemental oxygen for infants and small children.

EQUIPMENT

Croupette frame with rubber tube attachments
  Atomizer assembly with jar
  Canopy
Oxygen supply or compressed air
Oxygen gauge
Four feet of rubber tubing
Non-magnetic wrench
"No Smoking" signs
Distilled water
Tap water
Cracked ice
Drainage pan
Curved basin
Bath towel
Sheet

For Aerosol Nebulizer Add:

Neublizer or mistogen unit
Prescribed medication
Medicine dropper or 2cc syringe

PROCEDURE

1. Read instructions printed on back of Croupette.
2. Instruct patient as to what you are going to do.
3. Place Croupette frame on mattress at head of bed. Cover with and snap canopy into place.
4. Unscrew water jar. Fill with distilled water. Replace.
5. Attach rubber tubing to oxygen gauge.
6. Turn on oxygen 6 to 8 liters, unless otherwise ordered.
7. Connect other end of rubber tubing to oxygen intake nipple above water jar.

HUMIDITY AND OXYGEN THERAPY (Continued)

(Croupette)

PROCEDURE (Continued)

8. Open damper valve for 5 to 6 minutes, and bring to 100% humidity.
9. Close damper valve.
10. Fill chamber with ice unless otherwise ordered.
    a. Add tap water as directed.
    b. Hook end of rubber tubing from ice chamber to damper valve.
11. Keep short rubber tube in curved basin at back of Croupette.
12. Place patient's head under Croupette.
13. Tuck sides of canopy under frame. Bring front down over patient.
14. Fold cotton sheet in fourths. Place front of canopy within folds of sheet. Tuck sheet under mattress on both sides.

With Nebulizer

1. Put prescribed medication or distilled water in nebulizer with medicine dropper or syringe.
2. Insert nebulizer barrel into rubber grommet on back of croupette.
3. Attach rubber tubing to oxygen gauge.
4. Turn on oxygen 6 to 8 liters, unless otherwise ordered.
5. Attach other end of rubber tubing to nebulizer chamber.

POINTS TO EMPHASIZE

1. Use same PRECAUTIONS as required with any oxygen administration.
2. Do not use humidifier with oxygen gauge.
3. Carry out procedures through zippered openings.
4. See that patient is well covered and dry.
5. Keep jar filled with distilled water.

HUMIDITY AND OXYGEN THERAPY (Continued)

(Croupette)

POINTS TO EMPHASIZE (Continued)

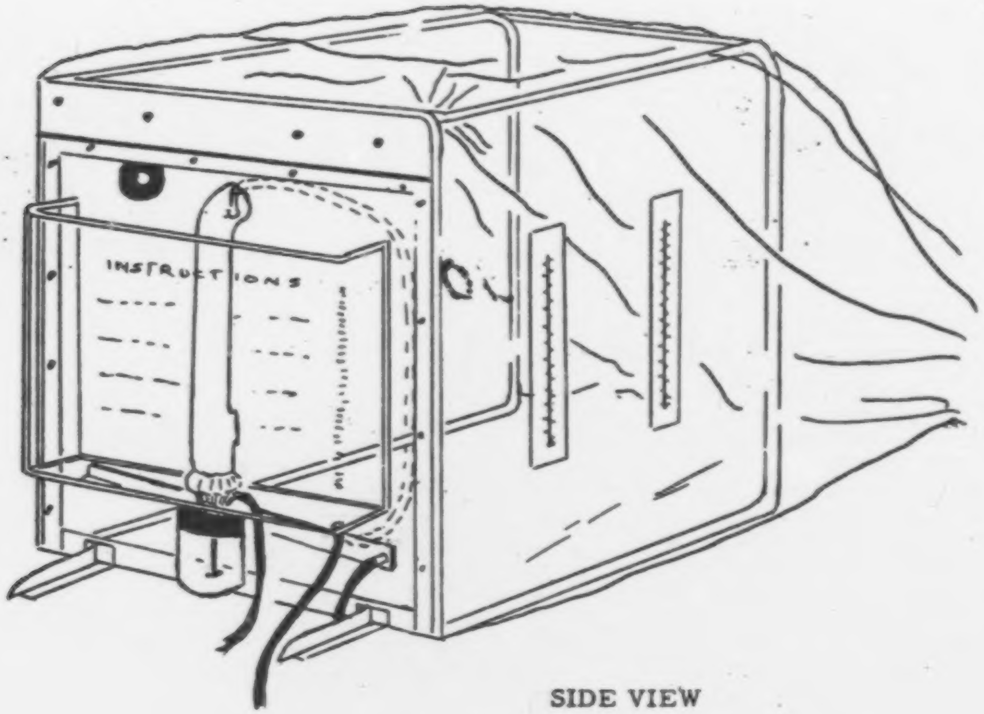
6. The combination of ice and water is necessary to provide maximum cooling.
7. Croupette may be used without ice when ordered.
8. Do not boil or expose plastic nebulizer to excessive temperatures.

CARE OF EQUIPMENT

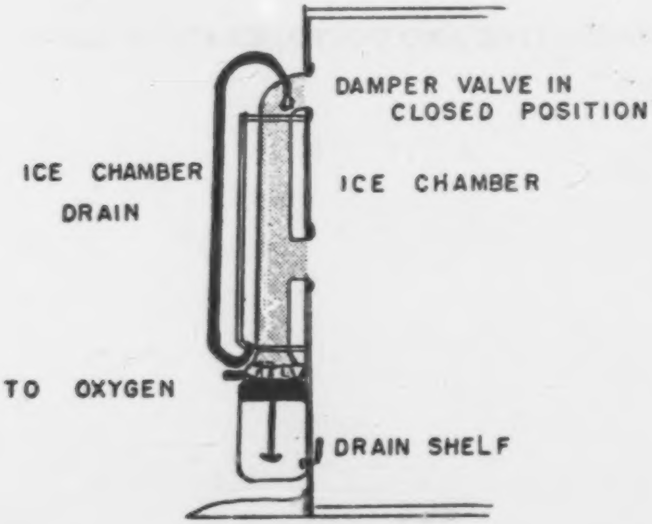
1. Drain ice chamber: Slip rubber tubing off damper valve and empty into pan on floor.
2. Remove, clean and replace screen filter on end of small rubber tube in water jar.
3. Empty, rinse, dry and replace water jar.
4. Wash ice chamber, frame, canopy and nebulizer with soap and warm water. Rinse and dry.
5. Clean atomizer unit only if clogged:
    - a. Remove by loosening three thumb screws under water jar cap.
    - b. Unscrew atomizer cap to expose atomizer tip.
    - c. Insert fine wire in tip and side holes to unblock openings.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CROUPETTE


INSTRUCTIONS

SIDE VIEW


DAMPER VALVE IN CLOSED POSITION
ICE CHAMBER
ICE CHAMBER DRAIN
TO OXYGEN
DRAIN SHELF

IV

PREOPERATIVE AND POSTOPERATIVE CARE

PREOPERATIVE PREPARATION

PURPOSE

To prepare the patient mentally and physically for surgery.

EQUIPMENT

Standard Form SF 517, Anesthesia, two with carbon
Standard Form SF 515, Tissue examination (5 part)
Standard Form SF 516, Operative Report or NavMed (Surgical Data Card)
Standard Form SF 518, Blood Transfusion if required
Standard Form SF 522, Authorization for Anesthesia, operations, etc.
Surgery Check-off List or Card
X-ray films if required
Medications as ordered

PROCEDURE

1. Day before surgery
   a. Instruct patient:
      (1) Regarding pre and postoperative activities, e.g. nothing by mouth after midnight unless otherwise ordered, time to be spent in recovery room, and postoperative deep breathing exercises and coughing.
   b. The following routine should be carried out. Have patient do it if he is able.
      (1) Check valuables with Disbursing Officer.
      (2) Shower or bathe.
      (3) Clean, clip fingernails, and remove nail polish.
   c. Prepare chart with the following:
      (1) Required x-ray and laboratory reports and EKG if applicable.
      (2) Completed history and physical exam report.
      (3) Signed authorization for anesthesia, SF 522 on all patients.
      (4) Two anesthesia reports with carbon, one Operative Report, one Tissue Examination Sheet (5 part) stamped with addressograph plate.
      (5) Surgery check-off list or card on chart holder.
      (6) Allergies noted on chart cover.
      (7) Note if patient is on S.L. or V.S.L.

PREOPERATIVE PREPARATION (Continued)

PROCEDURE (Continued)

1.
   - d. Prepare patient.
     - (1) Check to see if patient is wearing an identification band.
     - (2) Give cleansing enema if ordered.
     - (3) Prepare skin of operative site.
     - (4) Give medication as ordered.
   - e. Notify chaplain unless patient does not wish this.
2. Day of Surgery:
   - a. Early A.M. care to be given including oral hygiene and face shave.
   - b. Take and record T.P.R. and blood pressure.
   - c. Remove prosthesis. Label. Store in safe place.
   - d. Remove contact lenses, jewelry, dentures, and wigs.
   - e. Insert gastric tubes and catheters if ordered.
   - f. When called for by surgery:
     - (1) Have patient void.
     - (2) Give preoperative medication as ordered. Record on Medication Administration Record.
     - (3) Cover patient with clean sheet. Remove pajamas. Transfer to stretcher. Cover head with towel or cap according to local policy.
     - (4) Record transfer of patient to operating room on Nursing Notes (SF 510).
     - (5) Place chart with blood tags and x-rays (if required) on stretcher with patient.
     - (6) Tape addressograph plate to chart cover.
3. While patient is in surgery:
   - a. Prepare recovery bed. (See Recovery Unit, Page 330).
   - b. Obtain and set up all necessary equipment as needed.

POINTS TO EMPHASIZE

1. Patients are not generally given liberty 24 hours prior to surgery. (Refer to local hospital instruction).
2. Notify ward medical officer if patient has any signs or symptoms of cold, skin lesions, temperature elevation, or is unduly apprehensive.

PREOPERATIVE PREPARATION (Continued)

POINTS TO EMPHASIZE (Continued)

3. Wedding bands may be worn if secured to patient's finger by adhesive tape; except for patients who are to be under hypothermia, in which case the band must be removed.
4. In preparing women patients for surgery:
   a. Remove lipstick and nail polish.
   b. Remove bobby pins and combs. Braid long hair.
5. Requests for blood should be sent to the Blood Bank the day before surgery. (Check local hospital instruction).

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SKIN PREPARATION

PURPOSE

To cleanse the operative site as well as possible in preparation for a surgical incision.

EQUIPMENT

Bedlamp or spotlight
Razor
Razor blades
Basin of warm water and pHisoHex 1:3
Gauze sponges
Curved basin
Protective sheet or pads
Applicators
Sterile Towels)
Ace or gauze bandages) For Orthopedic preparation
Scissors
Clippers to cut hair of neurosurgery patients

PROCEDURE

1. Tell the patient what you are going to do.
2. Place light at best angle to see hairs.
3. Place protective sheet or pads under area to be shaved.
4. Clip long hairs with scissors.
5. Lather a small area at a time with pHisoHex.
6. Shave in direction of hair growth.
7. Scrub entire area with attention to folds of skin, umbilicus, toes, fingers and nails. Rinse.
8. Repeat scrub. Wipe off excess pHisoHex.
9. Shave lumbar region if spinal anesthesia has been ordered.

Note: For an orthopedic preparation, in addition to the above preparation, apply sterile towels to prepared area and secure with bandage.

POINTS TO EMPHASIZE

1. Refer to chart for proper area to be shaved.
2. Patient should have a bath or shower before preparation.
3. Avoid scratching or cutting skin.
4. If any skin lesion is noted report to medical officer before proceeding with preparation.

SKIN PREPARATION (Continued)

POINTS TO EMPHASIZE (Continued)

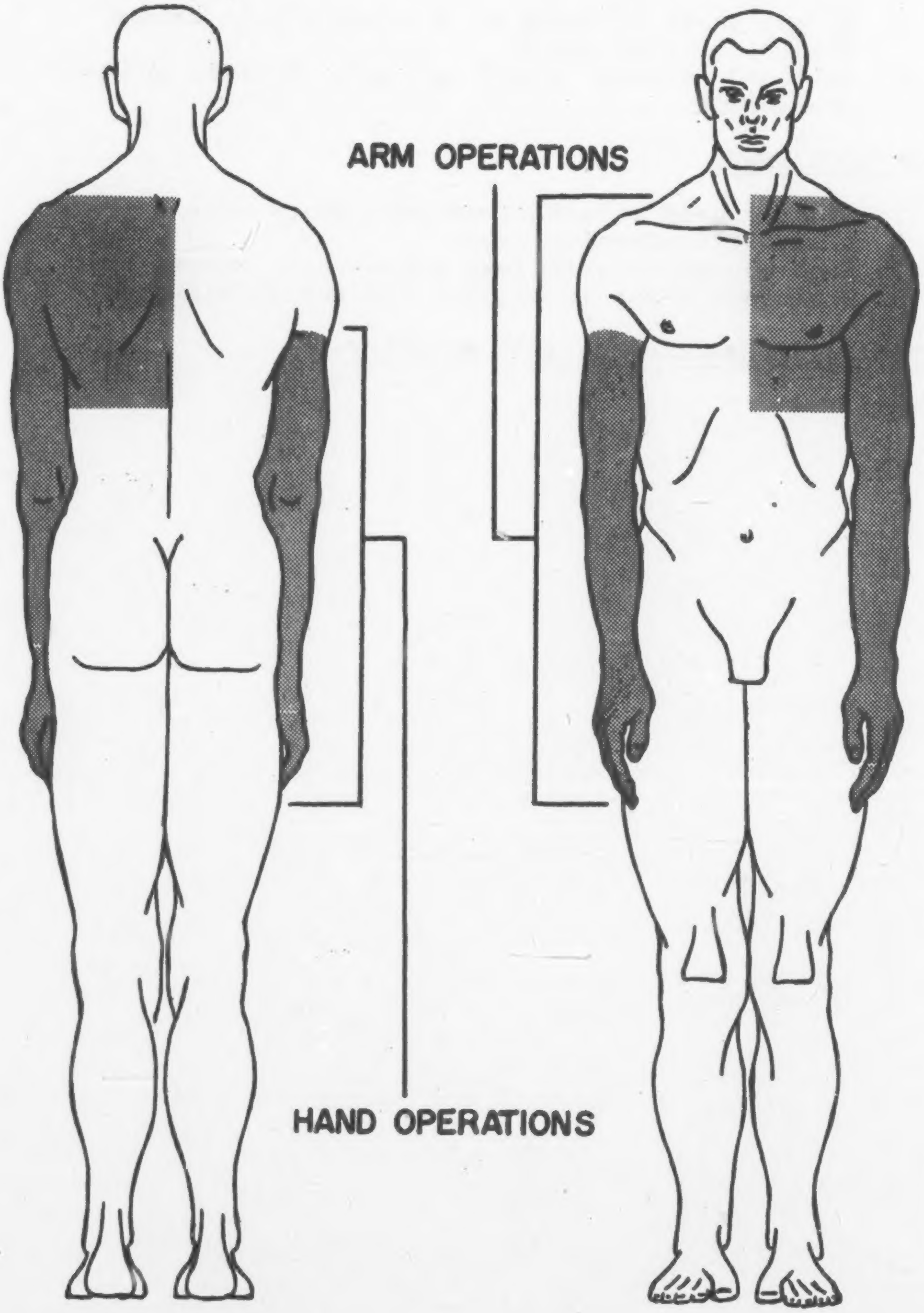
5. Do not shave eyebrows or a woman's face unless specifically directed.
6. Collect, package, label and save all hair removed from head.

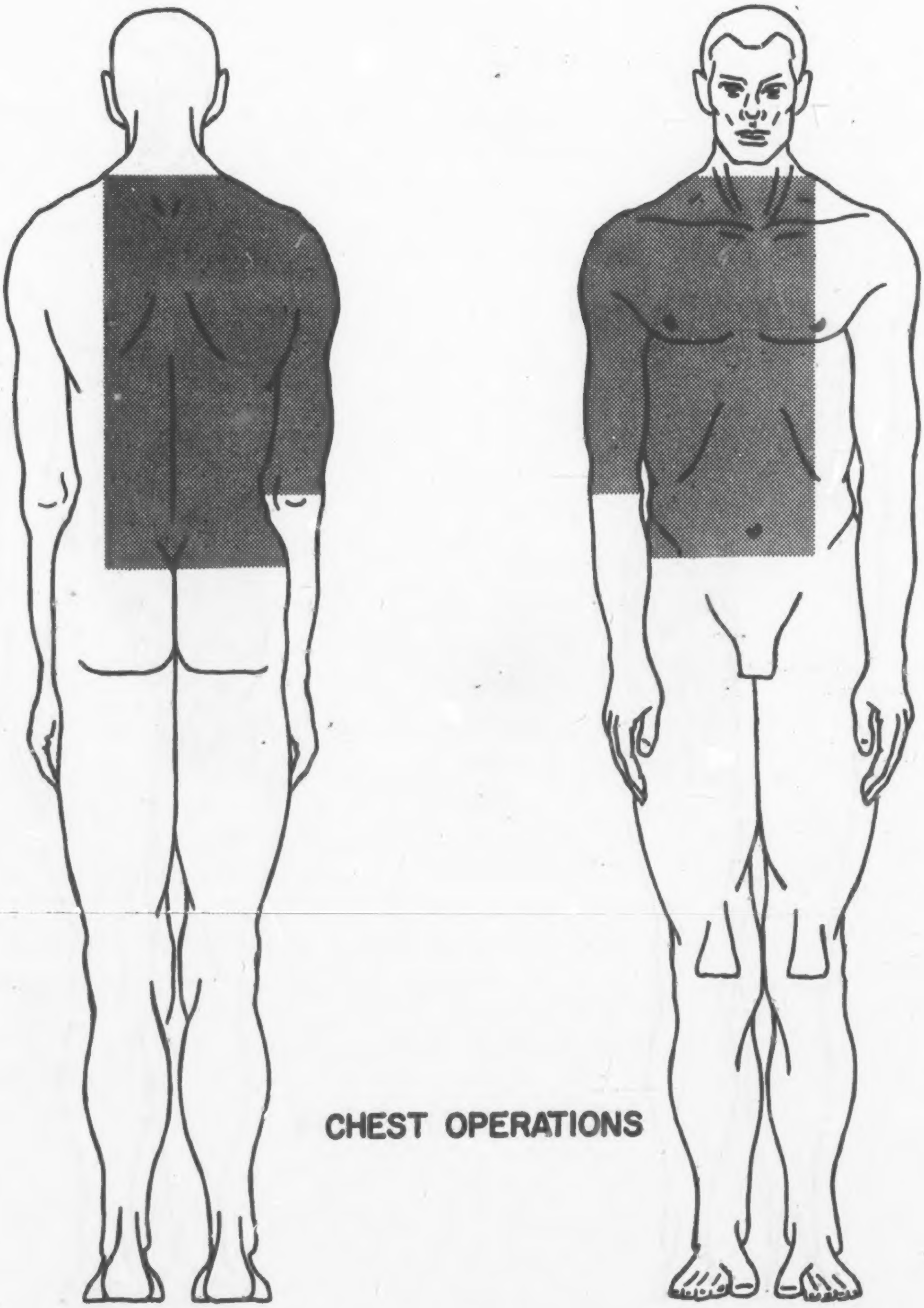
CARE OF EQUIPMENT

1. Discard used materials (secure sharp edge of razor blade with adhesive tape).
2. Wash equipment with soap and water. Rinse, dry.
3. Disinfect razor in alcohol 70% for 30 minutes.

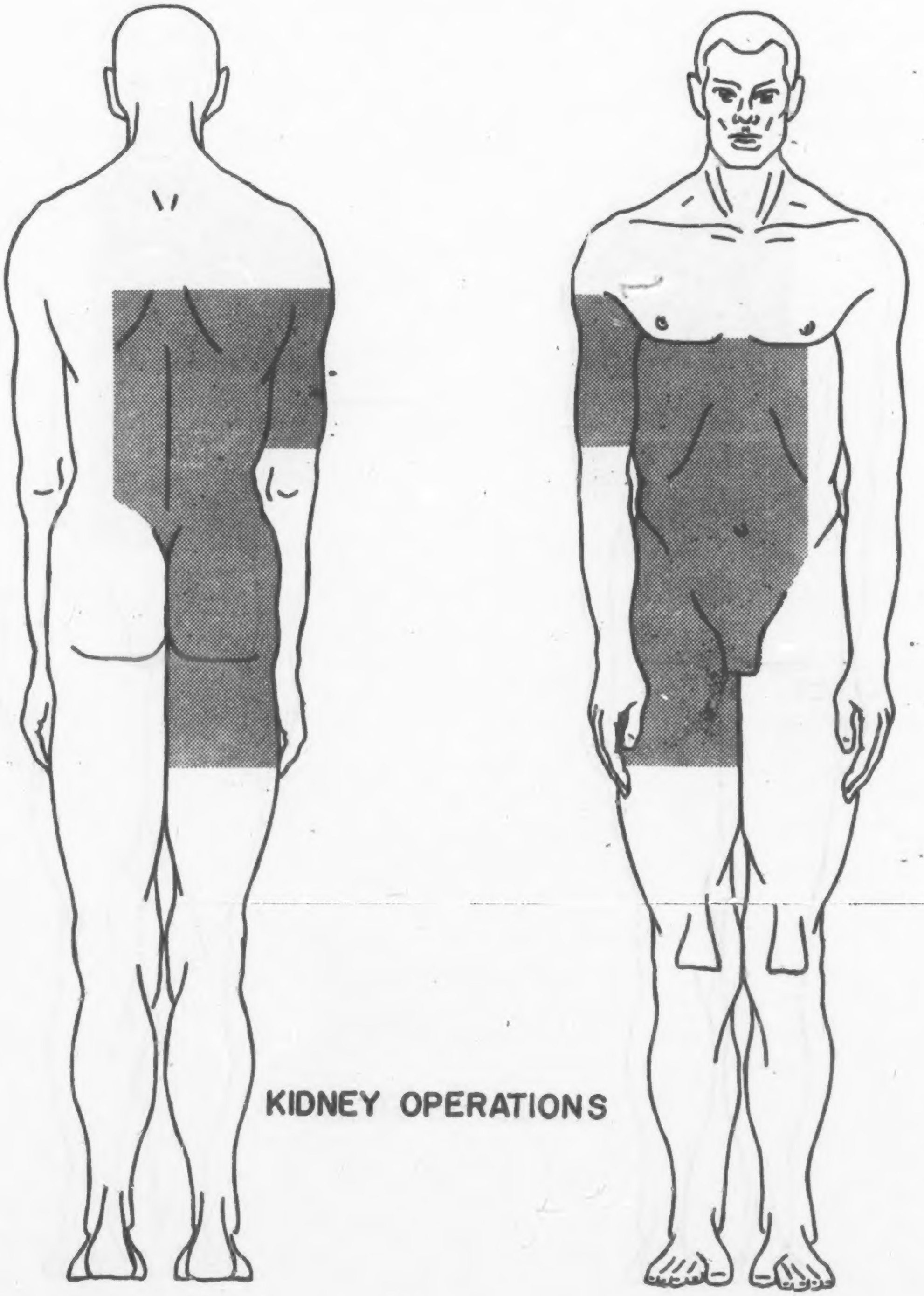
ADDITIONAL INFORMATION FOR THIS ACTIVITY

AREAS OF SKIN PREPARATION

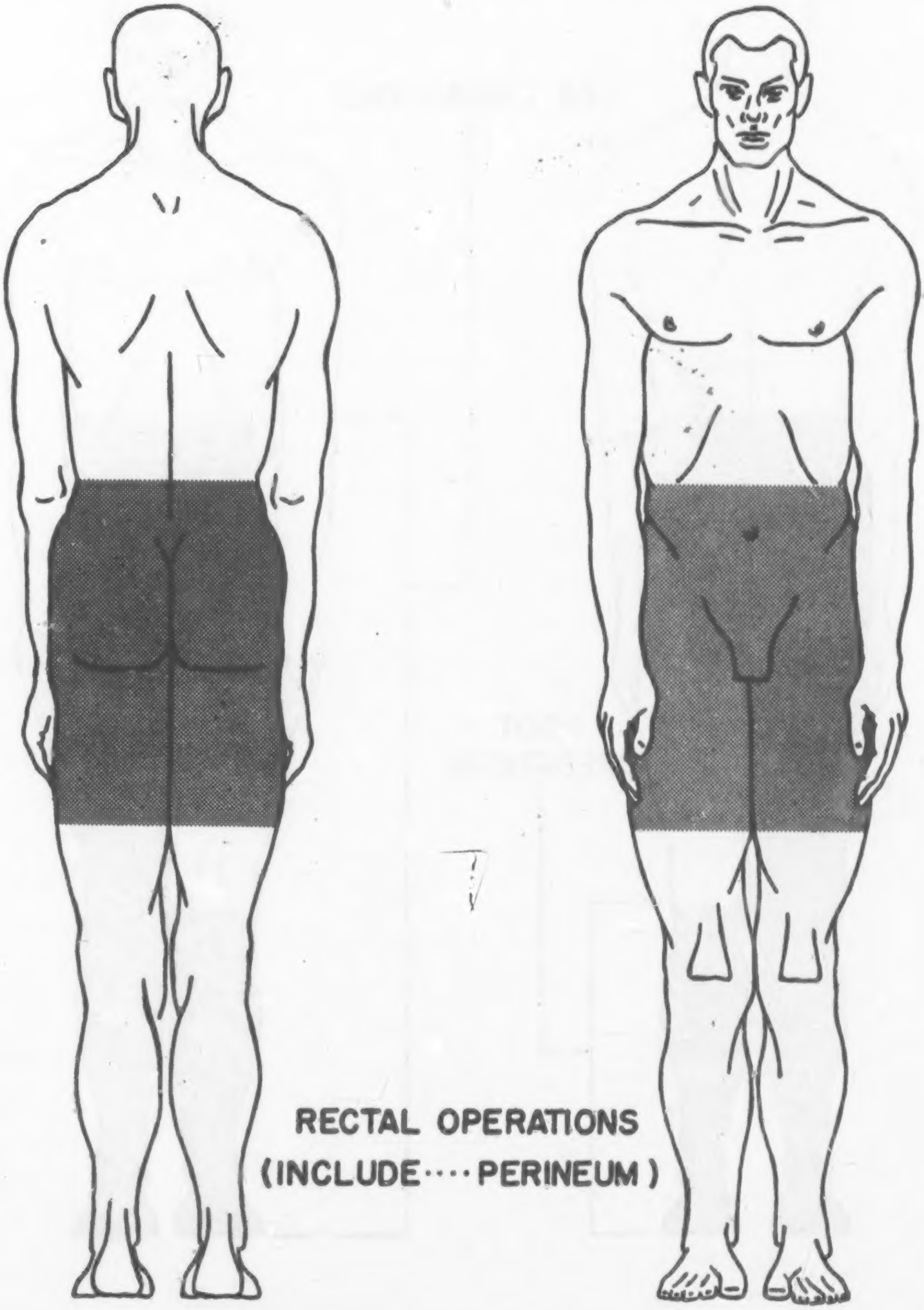

ARM OPERATIONS
HAND OPERATIONS



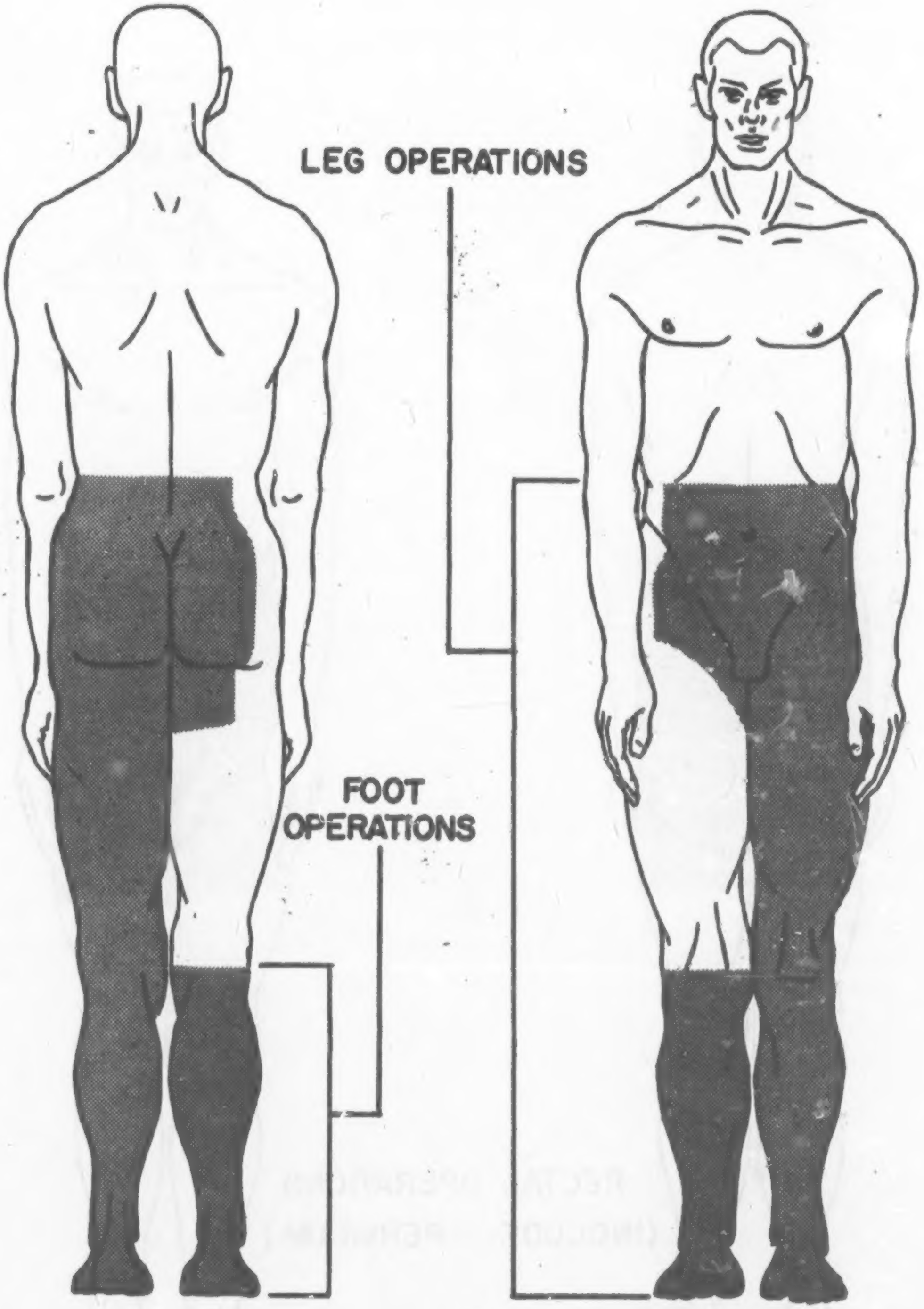
CHEST OPERATIONS

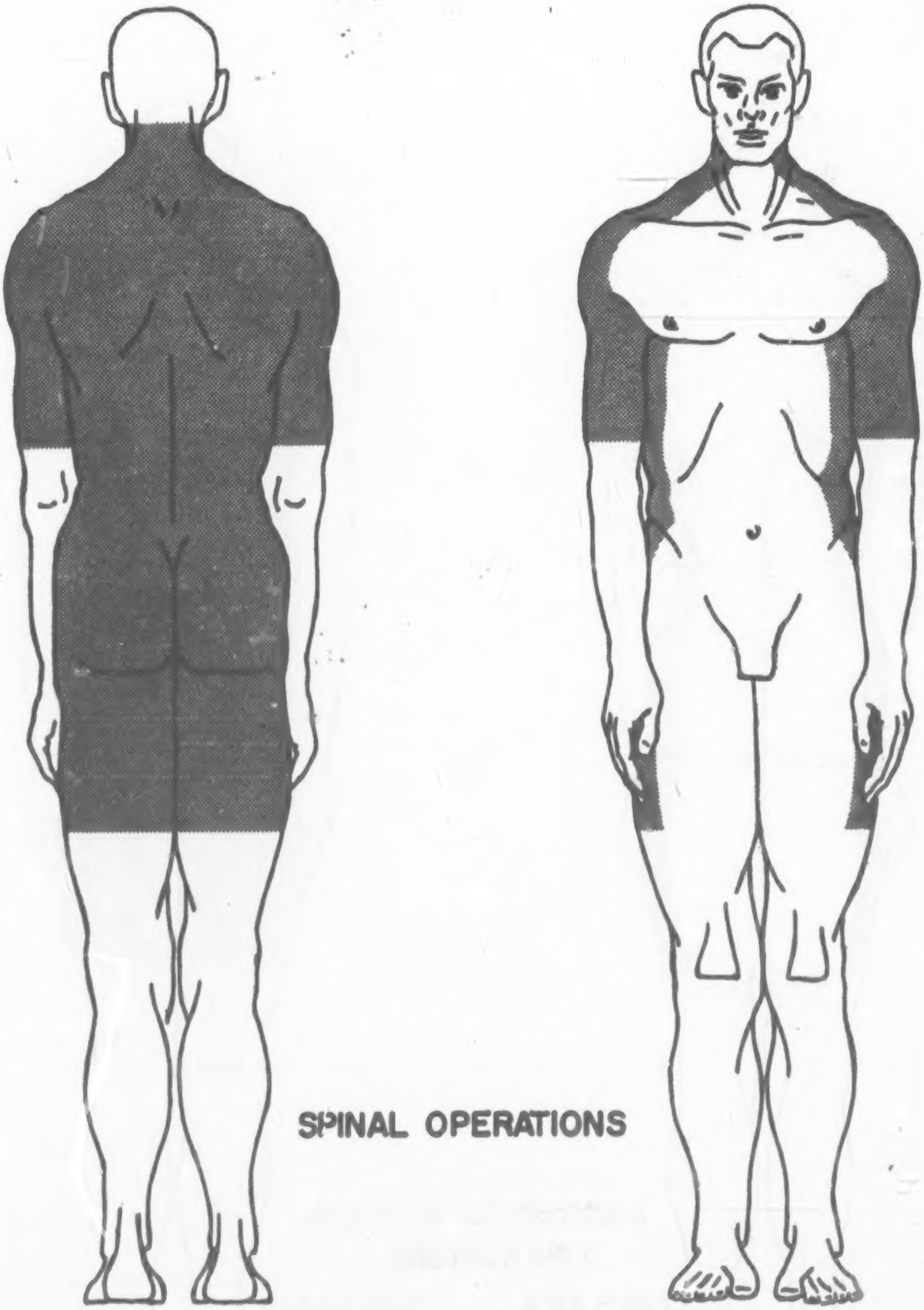


KIDNEY OPERATIONS

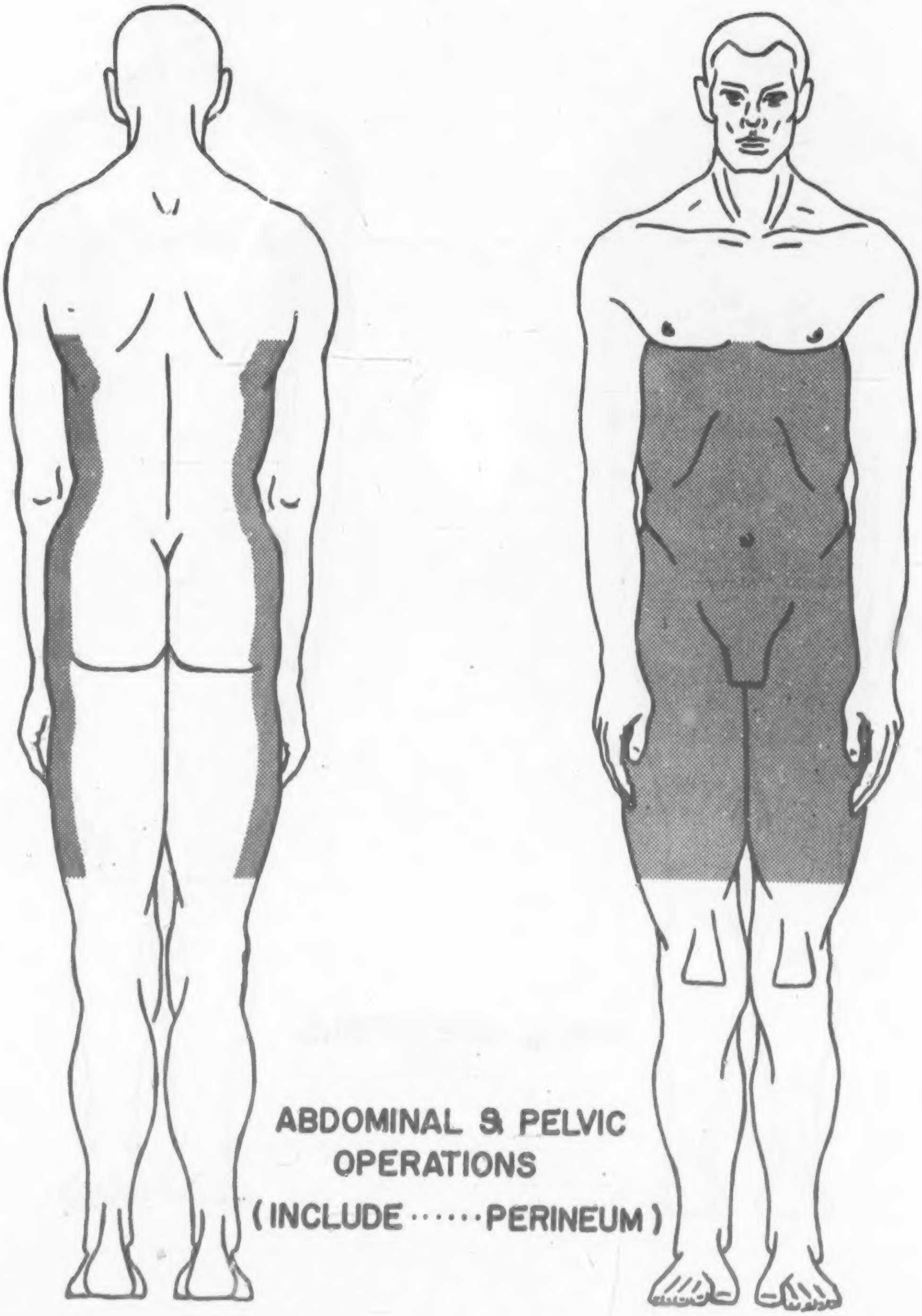


RECTAL OPERATIONS
(INCLUDE···· PERINEUM)


LEG OPERATIONS
FOOT OPERATIONS

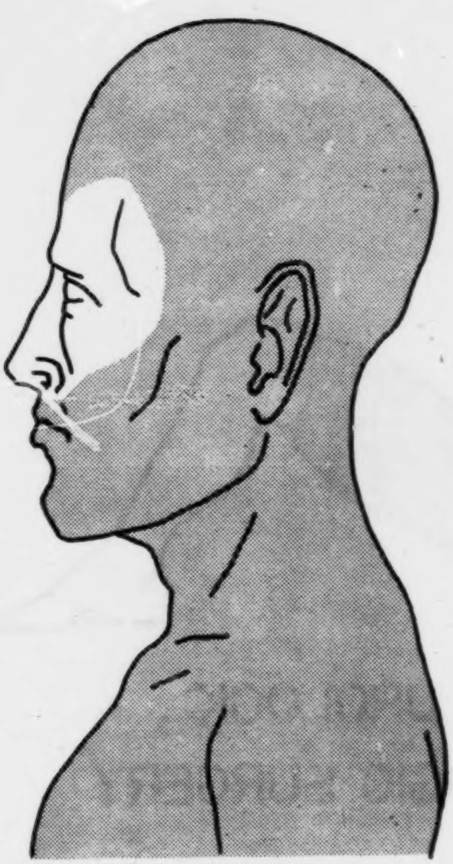


SPINAL OPERATIONS

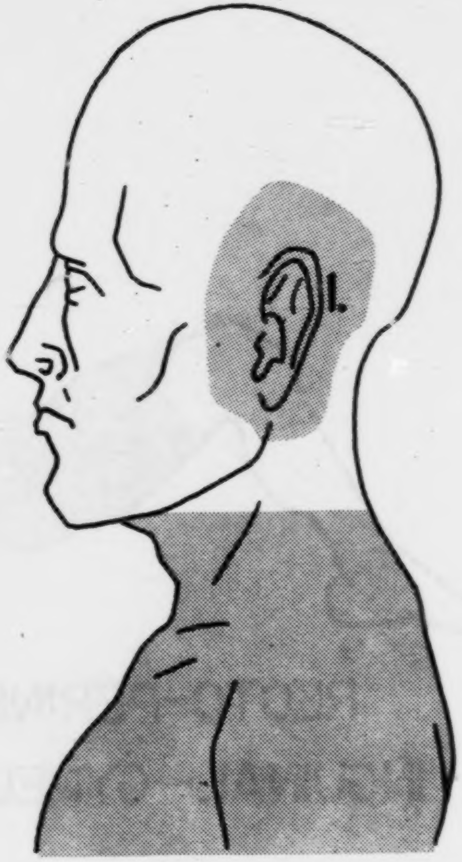


ABDOMINAL & PELVIC OPERATIONS

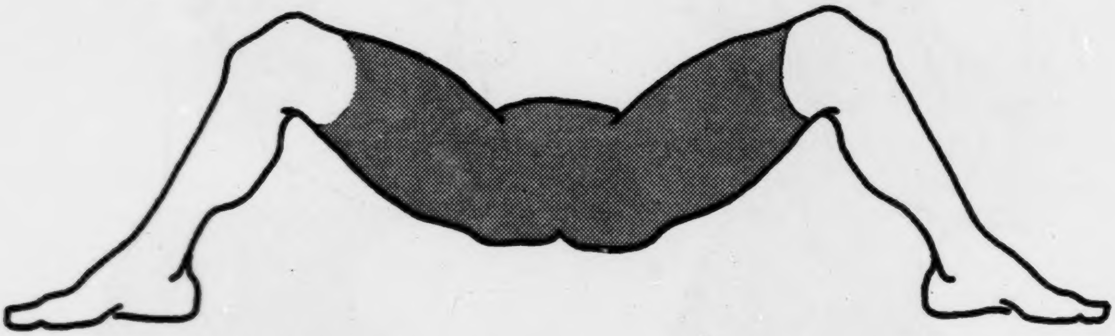
(INCLUDE ······ PERINEUM)



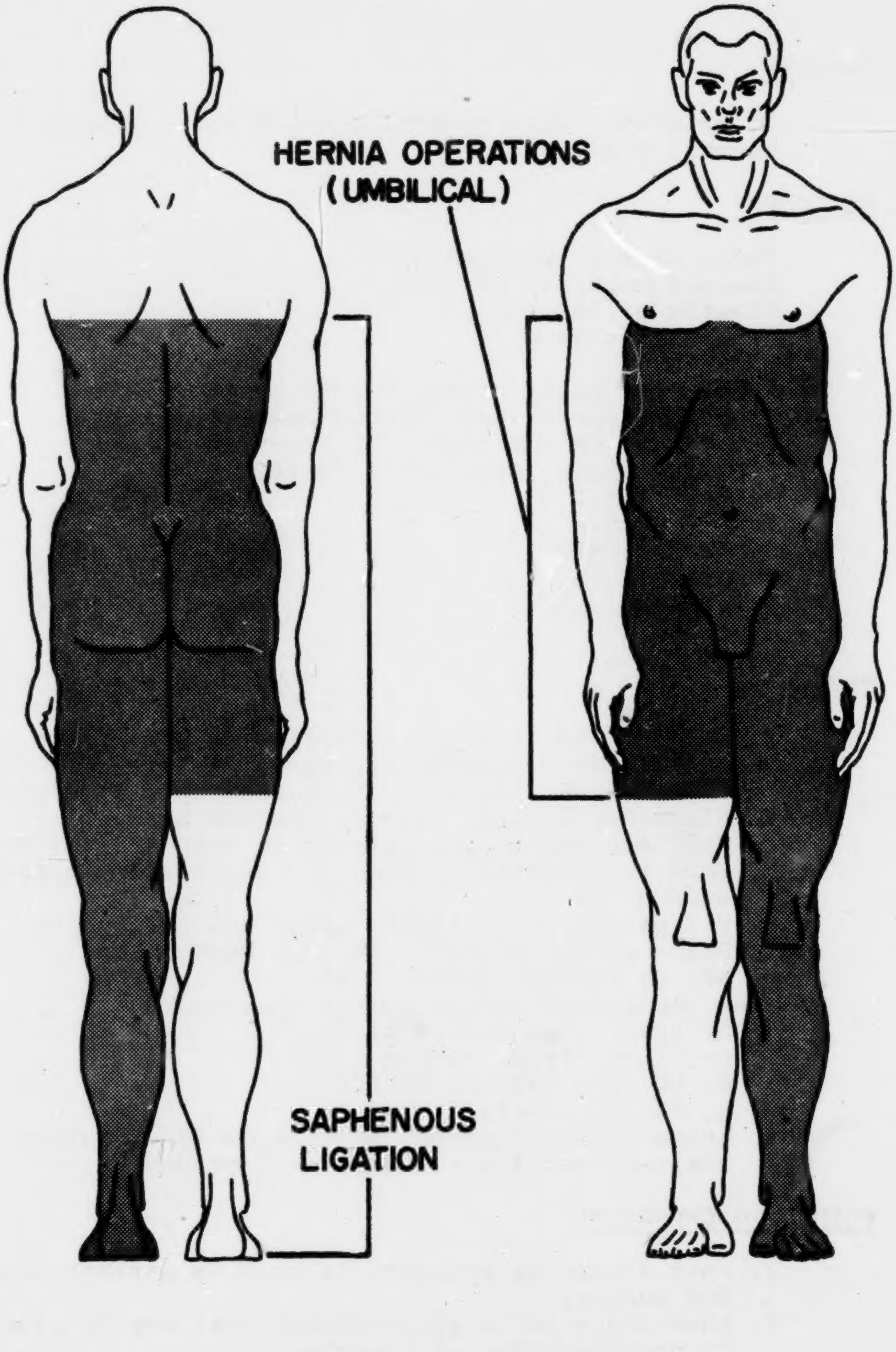
BRAIN OPERATIONS



MASTOID (I.)
&
THYROID OPERATIONS



RECTO-PERINEAL, UROLOGIC, INGUINAL-GYNECOLOGIC SURGERY


HERNIA OPERATIONS
(UMBILICAL)
SAPHENOUS
LIGATION

RECOVERY UNIT

PURPOSE

To provide a warm comfortable bed for the postoperative patient.

EQUIPMENT

Three sheets, pillowcase
Plastic mattress cover
Plastic pillow cover
Bed protective pads
Blanket
Paper bag, paper wipes, curved basin
Sphygmomanometer and stethoscope
Intake and Output sheet, DD Form 792
Plotting Chart, Standard Form 512
Pen or Pencil
Tongue blades
Suction machine
Infusion Stand
Oxygen equipment
Side rails

PROCEDURE

1. Make bottom of bed with full size protective sheet or full size plastic mattress cover.
2. Place protective pads in area of operative site.
3. Place top bedding on bed. Do not tuck in.
4. Fold top sheet over blanket at both ends of bed.
5. Fold top bedding to edge of mattress on entrance side of bed.
6. Fit pillow into plastic cover and pillowcase.
7. Place pillow between rungs at head of bed.
8. Set up bedside locker with:
   a. Sphygmomanometer and stethoscope
   b. Paper bag, curved basin.
   c. Paper wipes, tongue blades
   d. DD Form 792 and SF 512
   e. Pen or pencil
9. Bring infusion stand, suction machine, oxygen or drainage bottles to bedside if needed.

POINTS TO EMPHASIZE

1. Unit should be prepared as soon as patient leaves for surgery.
2. Know where to locate articles that may be needed in postoperative emergencies.
3. Check all equipment in unit to ascertain that it is in working condition.

RECOVERY UNIT (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

POSTOPERATIVE CARE

(Immediate)

PURPOSE

To provide close observation and care for a patient immediately after an operation and until he has reacted from anesthesia.

EQUIPMENT

Curved basin
Paper wipes, paper bag
Sphygmomanometer and stethoscope
Plotting Chart SF 512
Paper, pen or pencil
I. V. Standard
Intake and Output sheet, DD Form 792
Linen as necessary
Oxygen, drainage equipment, suction apparatus, tubings

PROCEDURE

1. Assist with transfer of patient from stretcher to bed.
2. Observe patient for symptoms of hemorrhage, shock or pain.
3. Take and record pulse, respiration and blood pressure immediately and then as ordered.
4. Put pajama top on patient. Arrange bed linen.
5. Check chart for postoperative orders.
6. Check for the presence of drainage tubes; connect as ordered.
7. Place patient in position ordered.
8. If patient had a general anesthesia:
    a. Keep patient's head to one side to prevent aspiration of vomitus.
    b. Suction as necessary.
    c. Remove airway when patient regains consciousness.
9. Inspect dressings at frequent intervals.

POSTOPERATIVE CARE (Continued)

(Immediate)

PROCEDURE (Continued)

10. Report bleeding and excess drainage, persistent nausea or vomiting.
11. Keep accurate intake and output record.
12. Follow doctor's orders for:
    a. Taking and recording vital signs.
    b. Turning patient.
    c. Coughing and deep breathing the patient.
    d. Catheterization.
    e. Irrigations.
    f. Ambulation.
    g. Pain and nausea
13. Check color and circulation of extremities.

POINTS TO EMPHASIZE

1. When transferring patient from gurney to bed, make sure adequate personnel are available.
2. Stay with patient until he is oriented as to name, time and place. Use side rails to protect him from falling out of bed.
3. Watch for symptoms of hemorrhage, shock or complaints of pain.
4. Be sure all tubes are connected, open and draining.
5. Teach patient to support incision when coughing.
6. Encourage patient to turn and help himself as much as allowed.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

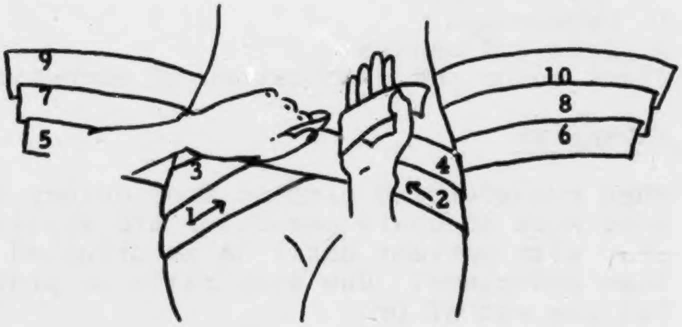
SCULTETUS BINDER

PURPOSE

To provide support to the abdominal region.

EQUIPMENT

Binder
Safety pins



PROCEDURE

1. Place binder under patient, three to four inches below hips.
2. Start at lowest tail. Lap one over the other to top.
3. Pin last two tails in place. Shaft of pin should be at right angles to pull of material.

POINTS TO EMPHASIZE

1. The first two tails should reach well over the hip bones and anchor the binder.
2. Considerable pull is used to obtain firm support. The patient's comfort is the guide.
3. The tails should overlap each other from one-half to two-thirds, depending on the contour of the abdomen.
4. If the tail is too long, turn it back on itself. There should not be wrinkles over the bony prominences.

SCHULTETUS BINDER (Continued)

POINTS TO EMPHASIZE (Continued)

5. The binder should be inspected frequently and reapplied as necessary.
6. As you pin binder, insert your fingers between patient and binder to protect him.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

STRAIGHT ABDOMINAL BINDER

PURPOSE

To hold abdominal dressings in place.
To give support.

EQUIPMENT

Straight Binder
Safety pins

PROCEDURE

1. Gather half of binder. Slip under patient's hips. Pull through and adjust evenly.
2. Bring ends together over middle of abdomen. Fold under ends to fit body snugly.
3. Pin with safety pins, starting from pubic area and work upward. Space pins about 2 inches apart at right angles to pull material.
4. Fit binder at waistline with safety pins.

POINTS TO EMPHASIZE

1. Be sure binder is smooth under patient.
2. As you insert pins, protect body by inserting fingers between patient and binder.
3. Avoid pinning over bony prominences or areas that may cause pressure.

CARE OF EQUIPMENT

Send binder to laundry when soiled.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

T BINDERS

PURPOSE

To hold perineal or rectal dressings in place.

EQUIPMENT

T Binder or double T Binder
Safety pins

PROCEDURE

T Binder (Female Patient)

1. Put the band around the patient's waist.
2. Tie or fasten with a pin in front.
3. Bring perineal strap up between legs and pin to waistband.

Double T Binder (Male Patient)

1. Place cross bar of T around patient's waist.
2. Bring double strips of T between legs, one on each side of scrotum to cross bar in front.
3. Pin in front with safety pins.

CARE OF EQUIPMENT

Send binder to laundry when soiled.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

BREAST BINDER

PURPOSE

To provide support and comfort to the breasts.

EQUIPMENT

Binder, Straight or Breast
Safety pins as required

PROCEDURE

1. Place binder smoothly under patient's shoulders.
2. Have patient support breasts upward and inward.
3. Bring ends of binder over breasts and tuck ends smoothly to fit body snugly. Pin binder securely.
4. Secure binder to contour of chest with safety pins.

POINTS TO EMPHASIZE

1. If fitted breast binder is used, bring straps over shoulders and pin in place.
2. As you pin binder, insert your fingers between patient and binder to protect him.

CARE OF EQUIPMENT

Send binder to laundry when soiled.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

DEVICES FOR THE SAFETY OF THE PATIENT
RESTRAINTS

PURPOSE

To protect the patient from injuring himself.
To protect the patient from injuring others.

EQUIPMENT

Side rails
Sheet restraints
Posey vest or belt
3 inch gauze roll
Leather ankle or wrist restraints

PROCEDURE

1. Side rails.
   a. Attach to beds of patients who are confused, delirious, under sedation, unconscious or subject to epileptic seizures.
2. Sheet restraints.
   a. Fold a sheet in quarters lengthwise and apply across patient's chest.
   b. Secure to bars under the bed.
   c. Requires a doctor's order.
3. Posey vest
   a. Patient should be on his back.
   b. Slip arms through sleeves of restraint and secure in back.
   c. Secure ties to sides of bed.
   d. Requires a doctor's order.
4. Gauze ankle and wrist restraints.
   a. Pad wrist and ankle.
   b. Attach to wrist and ankle of opposite side of body by means of a clove hitch.
   c. Never restrain all four extremities at the same time unless specifically ordered by medical officer.
   d. Requires a doctor's order.
5. Leather wrist or ankle restraints.
   a. Apply to one wrist and the opposite ankle.
   b. Pad wrist and ankle.
   c. Place cuff over pads.
   d. Pass strap through loop of cuff and under bar of bed.
   e. Allow enough slack in strap to permit movement.
   f. Lock strap.
   g. Requires a doctor's order.

DEVICES FOR THE SAFETY OF THE PATIENT (Continued)

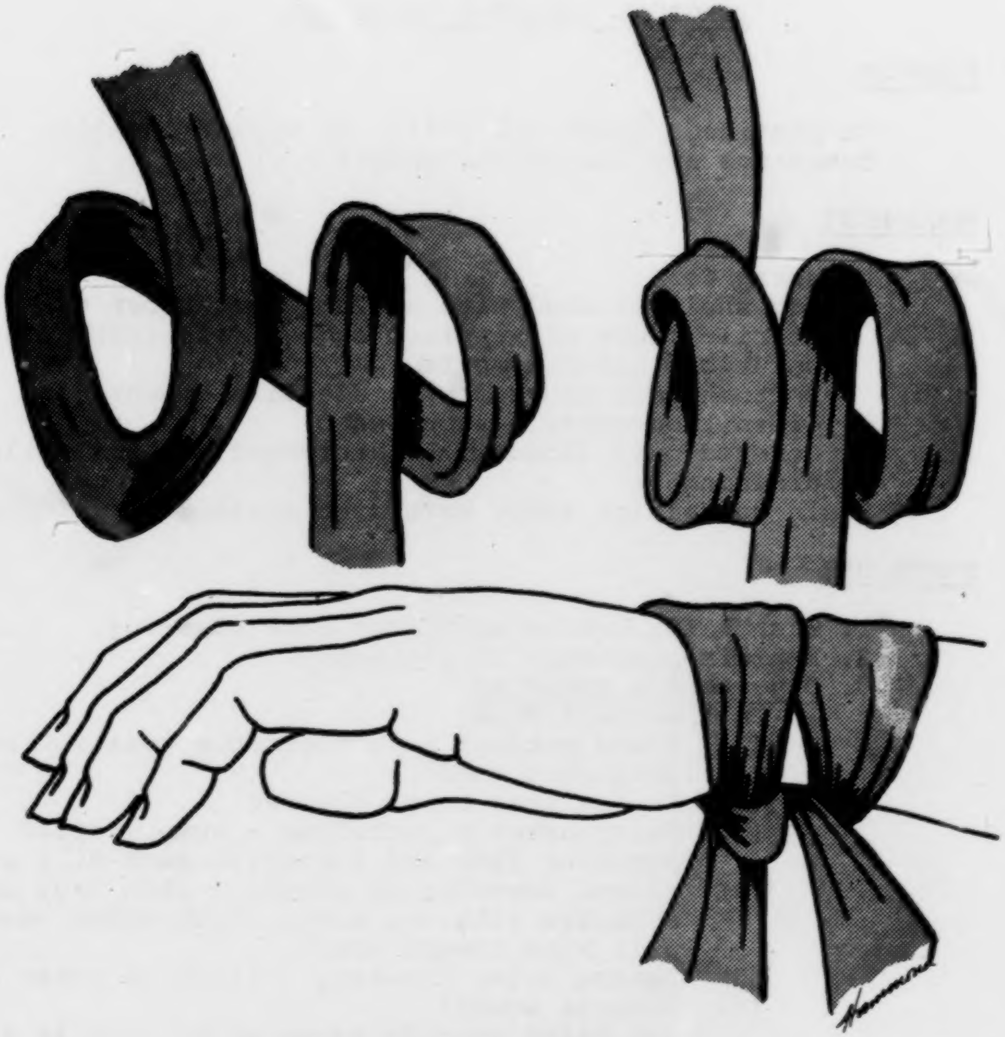
POINTS TO EMPHASIZE

1. All physical restraints must have a doctor's order.
2. When applying the sheet restraint be careful not to impair respirations.
3. When applying wrist and ankle restraints watch for chafing, burning or pressure sores.
4. Pulse should be taken at regular intervals for patients who are struggling against restraints.
5. Remove patients from restraints at least every two hours for change of position or exercise. Give skin care frequently.

CARE OF EQUIPMENT

Wash Posey restraints as needed and when order discontinued.

ADDITIONAL INFORMATION FOR THIS ACTIVITY



CLOVE HITCH

SURGICAL DRESSING TECHNIQUE

PURPOSE

To provide a quick and efficient way of changing dressings and irrigating wounds.

EQUIPMENT

Dressing Cart:
    Top shelf stocked with an adequate number of sterile packs of supplies and sterile instruments, solutions and ointments.
    Bottom shelf stocked with adequate amounts of clean, non-sterile supplies
    Covered pail lined with waterproof bag for soiled dressings
Basin containing soapy water for soiled instruments

PROCEDURE

1. Wash hands before and after each dressing.
2. Explain procedure to patient.
3. Dry Sterile Dressing
    a. In treatment room:
        (1) Place patient in comfortable position on treatment table.
        (2) Expose area to be dressed.
        (3) Using aseptic technique - open sterile instrument pack and a sterile pack of 4 x 4s.
        (4) Loosen dressing by pressing skin taut under adhesive with one hand. With other hand, pull tape toward wound.
        (5) Remove outer dressing. Place in paper bag.
        (6) Cleanse wound:
            (a) Using sterile hemostat or sterile glove pick up sterile 4 x 4.
            (b) Moisten by pouring antiseptic solution over 4 x 4.
            (c) Cleanse incision, wiping in circular motion from wound outward.
        (7) Apply sterile dressing to cover wound.
            (a) If disposable gloves are used, remove and discard with old dressing.
        (8) Remove all adhesive tape marks from skin with adhesive remover.
        (9) Pick up adhesive tape. Fasten tape to skin on far side of wound. Pull tape taut over dressing and fasten to near side.

SURGICAL DRESSING TECHNIQUE (Continued)

PROCEDURE (Continued)

3. Dry Sterile Dressing
    a.
        (10) Place instruments in container of soapy solution.
        (11) Assist patient to bed if necessary.
    b. At bedside of patient:
        (1) Screen patient and explain what you are going to do.
        (2) Wheel dressing cart to bedside. Keep at such distance to prevent contamination from patient's linen. Use dressing tray, if available.
        (3) Protect bed as necessary.
        (4) Follow above procedure for changing dressings.
        (5) Wheel dressing cart to dressing room. Clean and restock.
4. Vaseline Gauze Dressing
    a. Tear open one end of vaseline gauze package.
    b. Remove vaseline gauze with sterile hemostat.
    c. Cut desired length with sterile scissors.
    d. Place gauze on wound.
    e. Cover with dry sterile dressing. Secure with adhesive tape.
5. Suture Removal.
    a. Place 4 x 4 gauze sponge near incision.
    b. Clean suture line with antiseptic solution.
    c. Hold knot with hemostat.
    d. Slip scissors under suture. Clip close to knot.
    e. Remove sutures with hemostat. Place on 4 x 4. Discard.
    f. Cleanse incision with sponge moistened with antiseptic solution after all sutures to be removed are removed.
    g. Apply dressing if necessary.
6. Skin Clips
    a. Slip clip remover gently under clip.
    b. Squeeze handles of the clip remover.
    c. Gently lift clip from skin. Place on 4 x 4. Discard.
    d. Cleanse incision with 4 x 4 gauze sponge moistened with antiseptic solution.
    e. Apply dressing if necessary.

POINTS TO EMPHASIZE

1. Wash hands before and after changing each dressing.

SURGICAL DRESSING TECHNIQUE (Continued)

POINTS TO EMPHASIZE (Continued)

2. Order of dressings if more than one is to be done:
   a. Clean, closed wounds.
   b. Clean, open wounds.
   c. Contaminated wounds.
3. Do not put stoppers or covers of sterile containers where the inner surface comes in contact with an unsterile object.
4. Take care not to inadvertently remove drains or tubes when changing dressing.
5. Use Montgomery straps for wounds requiring frequent dressing changes.
6. Record in nursing notes when dressings are changed. Note type and amount of drainage present.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

WOUND IRRIGATION

PURPOSE

To wash out a wound and remove debris or purulent drainage.

EQUIPMENT

Disposable irrigation kit, or:
  Sterile bulb syringe
  Sterile round basin
  Sterile irrigating solution as ordered
  Curved basin
  Protective sheet or pads
  Dressing cart
  Sterile gloves

PROCEDURE

1. Wash hands before and after procedure.
2. Explain procedure to patient.
3. Place protective sheet or pads under part to be irrigated.
4. Place curved basin under wound.
5. Place sterile solution in sterile round basin.
6. Fill sterile bulb syringe with sterile solution.
7. Gently irrigate wound until returns are clear.
8. Apply dressing.
9. Leave patient clean and comfortable.
10. Record type of solution used, condition of wound, and character of drainage on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Note character, odor and appearance of discharge.
2. Record on Nursing Notes condition of wound.

CARE OF EQUIPMENT

1. Disinfect, wash, rinse, dry, and return used equipment to CSR.
2. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TRACHEOTOMY CARE AND CARE OF TRACHETOMY TUBE

PURPOSE

To maintain clear airway when a tracheotomy tube is in place.

EQUIPMENT

Obturator to fit tracheotomy tube the patient is wearing
Paper and pencil
Sterile tracheotomy tray, extra tracheotomy tube set
Naso-pharyngeal suction machine and tray containing:
  Naso-pharyngeal catheter F 6 or 8
  Hydrogen peroxide, fresh solution
  Sterile saline or sterile distilled water
  Two sterile basins
  Y tube connector
  Pipe cleaners
  Gauze sponges for cleaning tube
  Sterile gloves

PROCEDURE

1. Tell patient what you are going to do.
2. Wash hands. Put on sterile gloves.
3. Release safety clasp, place fingers on outer tube, support and hold outer cannula, and slowly withdraw inner cannula.
4. Place inner cannula in basin of hydrogen peroxide. Leave immersed until solution stops bubbling.
5. Applying friction, clean thoroughly with gauze and pipe cleaners until all mucous has been removed.
6. Immerse inner cannula in water or saline for rinsing. Agitate as required to remove lint or threads. Gently shake to remove droplets.
7. Suction outer cannula, if necessary, before reinstating inner cannula.
8. Reinsert inner cannula and carefully fasten safety clasp.
9. Change dressing under outer cannula, if necessary.
10. To provide moistness of inspired air and to protect from inspiration of irritating foreign materials, suspend sterile 4 x 4 moistened with sterile normal saline or sterile distilled water over opening if required.
11. Sigh patient 2-3 times after suctioning (Page 348A).
12. Disconnect catheter, rinse under cold water, and place with other equipment to be returned to CSR. Discard disposable catheter if used.

TRACHEOTOMY CARE AND CARE OF TRACHETOMY TUBE (Continued)

PROCEDURE FOR SUCTION

1. Explain what you are going to do and place patient in comfortable position.
2. Wash hands.
3. Turn on suction machine.
4. Put on sterile gloves for handling sterile catheter.
5. Attach sterile catheter to Y connector and test patency of tubing by drawing sterile water through them.
6. Insert catheter about 5 inches into cannula with Y tube open.
7. Close Y valve with thumb. Remove catheter gently and slowly with rotary motion.
8. Clear catheter and tubing by drawing water through them.
9. Repeat steps 6 through 8 until tubes are clear.
10. Permit patient to rest in between insertions of catheter as indicated by respiratory rate and/or difficulty.
11. Turn off suction machine.
12. Disconnect catheter, rinse under cold water, and place with other equipment to be returned to CSR. Discard disposable cathether if used.
13. Observe amount and character of material suctioned and reaction of patient. Record on Nursing Notes (SF 510)

POINTS TO EMPHASIZE

1. Never leave a new tracheotomy patient alone.
2. Clean inner cannula and/or suction patient at any sign of respiratory difficulty.
3. Use surgical asceptic technique.
4. Have sterile dilator or hemostat at bedside unit visible at all times.
5. If outer cannula is expelled, use dilator or hemostat to spread wound open so patient can breathe while waiting for medical officer to insert new tubes.
6. Notify nurse, medical officer, if it becomes impossible to remove or reinsert inner cannula.
7. Do not try to combine parts of two different tube sets.
8. Keep patient's signal cord or bell and pencil and paper within his reach at all times.
9. Allow patient to rest and breathe between suctioning. Never keep suction catheter within tube over 15 seconds.
10. Keep obturator matching tracheotomy tubes visible at bedside unit.

TRACHEOTOMY CARE AND CARE OF TRACHEOTOMY TUBE (Continued)

POINTS TO EMPHASIZE (Continued)

11. Handle silver tracheotomy tube parts gently; they are very soft and bend easily.
12. If possible, all patients with artificial airways in place should have a ventilating bag with the proper adapter to fit their tracheostomy/endotracheal tube at the bedside.

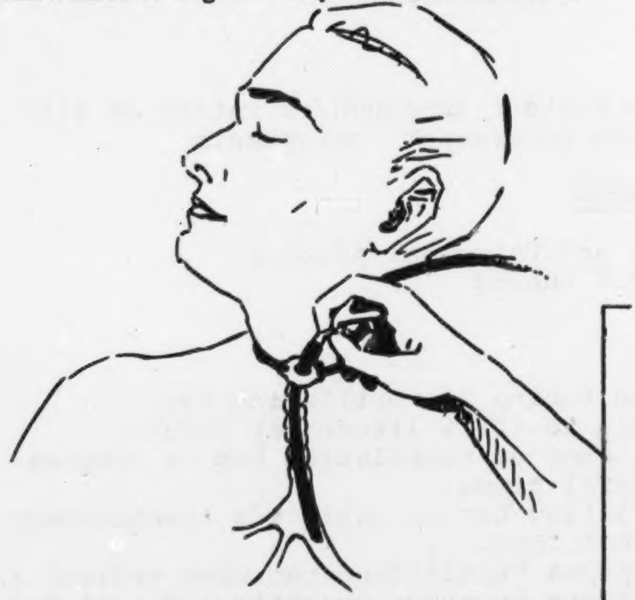
CARE OF EQUIPMENT

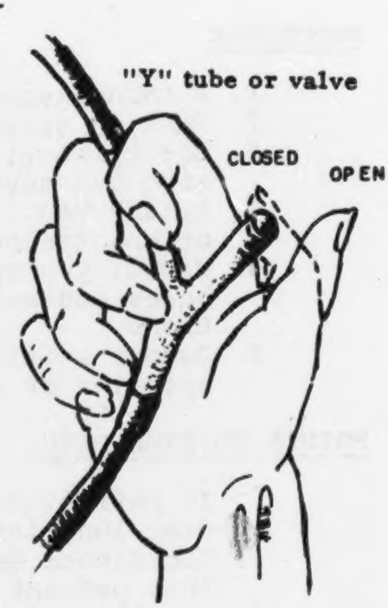
1. Clean and return used tracheotomy sets to CSR.
2. Clean suction apparatus.
3. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

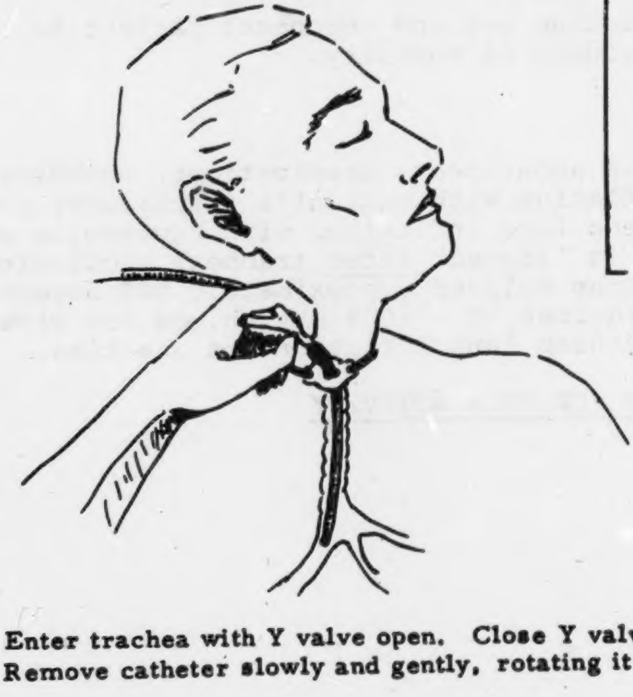
TRACHEOTOMY SUCTION

Turn head to right to aspirate left bronchus.




"Y" tube or valve
CLOSED
OPEN

Turn head to left to aspirate right bronchus.



Enter trachea with Y valve open. Close Y valve with thumb. Aspirate. Remove catheter slowly and gently, rotating it at same time.

PERIODIC DEEP LUNG INFLATIONS FOR PATIENTS WITH AN ARTIFICAL AIRWAY

(Sighing)

PURPOSE

To provide intermittent thorough inflation of all parts of the lung to prevent atelectasis.

MANUAL SIGHING EQUIPMENT

Ventilating bag and Universal adaptor
Oxygen source and tubing

PROCEDURE

1. Attach oxygen tubing to ventilating bag.
2. Turn on oxygen to 10-15 liters per minute.
3. Check functioning of ventilating bag by compressing bag several times.
4. Attach ventilating bag to patient's tracheostomy or endotracheal tube.
5. Manually compress ventilating bag when patient inhales and release pressure abruptly. Repeat 5-6 times.
6. Remove ventilating bag and reconnect patient to respirator or source of humidity.

POINTS TO EMPHASIZE

1. If patient has spontaneous respirations, coordinate deep lung inflation with patient's inspiratory phase.
2. Coordinate deep lung inflations with suctioning so that patient is "sighed" after tracheal suctioning.
3. Ventilating bags deliver approximately 50% oxygen. If patient requires 70 - 100% oxygen, do not give more than 3-4 deep lung inflations at one time.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

VENTILATOR SIGHING

PURPOSE

To provide intermittent thorough inflation of all parts of the lung to prevent atelectasis.

PROCEDURE

1. MA-1 and Emerson ventilators mechanically sigh the patient according to settings ordered by the doctor.
2. Air Shield ventilator: To deliver a sigh, increase INSPIRATORY TIME setting.
3. Bennet PR-1 and PR-2 ventilators: Remove plastic cap from valve lever. Manually depress lever to deliver the desired tidal volume.
4. Bird: Manually push in valve lever located on sensitivity control side of machine until desired volume is delivered.

POINTS TO EMPHASIZE

1. Ideal volume for sighing is usually 1 1/2 - 2 times the usual tidal volume.
2. A sigh should not exceed three liters of volume or 60 cm water pressure without consulting the doctor.
3. The most important guide to effective sighing is an increase in the excursion of the patient's chest.
4. When sighing a pediatric patient, the doctor should be present.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CHANGING TRACHEOSTOMY DRESSING

PURPOSE

To prevent infections and irritation of skin around tracheostomy stoma.

EQUIPMENT

Sterile applicators
Sterile 4 x 4 gauze (pre slit, if available)
Sterile scissors
Sterile gloves
Sterile water (5 cc ampule)
Hydrogen peroxide
Betadine ointment, or as prescribed by the doctor
Tracheostomy tapes

PROCEDURE

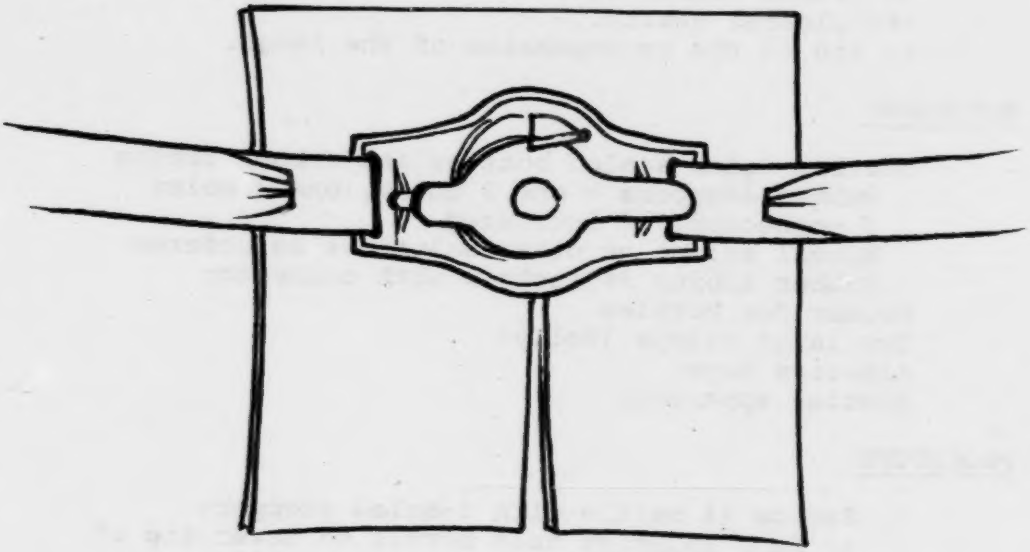
1. Wash hands. Take equipment to bedside.
2. Tell patient what you are going to do.
3. Open equipment, maintaining sterile technique.
4. Carefully remove old dressing. Do not untie tapes holding the tubes in place.
5. Put on sterile gloves.
6. Moisten a sterile applicator with hydrogen peroxide and wash area around stoma. Discard applicator.
7. Moisten a sterile applicator with sterile water and wash around stoma. Discard applicator.
8. Dry area around stoma with dry sterile applicator. Discard applicator.
9. Apply a thin film of ointment if prescribed by doctor with a dry sterile applicator.
10. Cut a slit in sterile 4 x 4 and place between the tracheostomy tube collar and the skin.

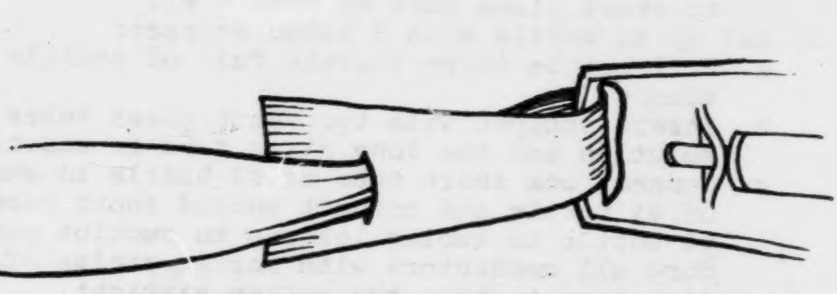
POINTS TO EMPHASIZE

1. Dressings should be changed when they become saturated with secretions or wound drainage. At least every three hours the first few days and then twice daily.
2. The tracheostomy tapes hold the tracheostomy tube in place. If it becomes necessary to change them, the tube must be supported and held in place by a second person during the procedure.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TRACHEOSTOMY DRESSING





TRACHEOSTOMY TUBE TAPES

WATER-SEALED CHEST DRAINAGE

PURPOSE

To remove fluid, blood or air that accumulate in the pleural cavity.
To aid in the re-expansion of the lungs.

EQUIPMENT

Sterile water sealed bottles and rubber tubing
  Rubber stoppers - one 2 holed, one 3 holed
  Y connector, if indicated
  Normal saline or other solutions as ordered
  Rubber tubing 36 inches, with connector
Holder for bottles
Two large clamps (Kelly)
Adhesive tape
Suction apparatus

PROCEDURE

1. Set up #1 bottle with 2-holed stopper:
   a. Pour solution into bottle to cover tip of long tube.
   b. Place piece of tape on bottle showing fluid level.
   c. Insert stopper with one short and one long glass tube. Tip of long tube must be below fluid level.
   d. Attach 36" rubber tubing to end of long glass tube in stopper. Short rubber tube is attached to short glass tube of bottle #1.
2. Set up #2 bottle with 3 holed stopper:
   a. Fill bottle three fourths full of sterile solution.
   b. Insert stopper with two short glass tubes above solution and one long glass tube in solution.
   c. Connect one short tube of #2 bottle to short tube of #1 bottle and connect second short tube of #2 bottle to tubing leading to suction pump. Secure all connectors with narrow strips of adhesive tape to keep the system airtight.
3. Explain procedure to patient. Tell him what you are going to do and what he is to do.
4. Place bottles in holder on floor at patient's bedside.

WATER-SEALED CHEST DRAINAGE (Continued)

PROCEDURE

5. Assist doctor to:
   a. Attach tubing from bottle #1 (collection bottle) to chest drainage tube(s).
   b. Connect tubing from bottle #2 (suction control bottle) to suction machine.
   c. Turn on suction machine to low pressure.
6. Watch for rise and fall of fluid in long tubes. If this stops - notify medical officer immediately. Clamp chest tubes.
7. Charting - include description and amount of drainage and effect on patient on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

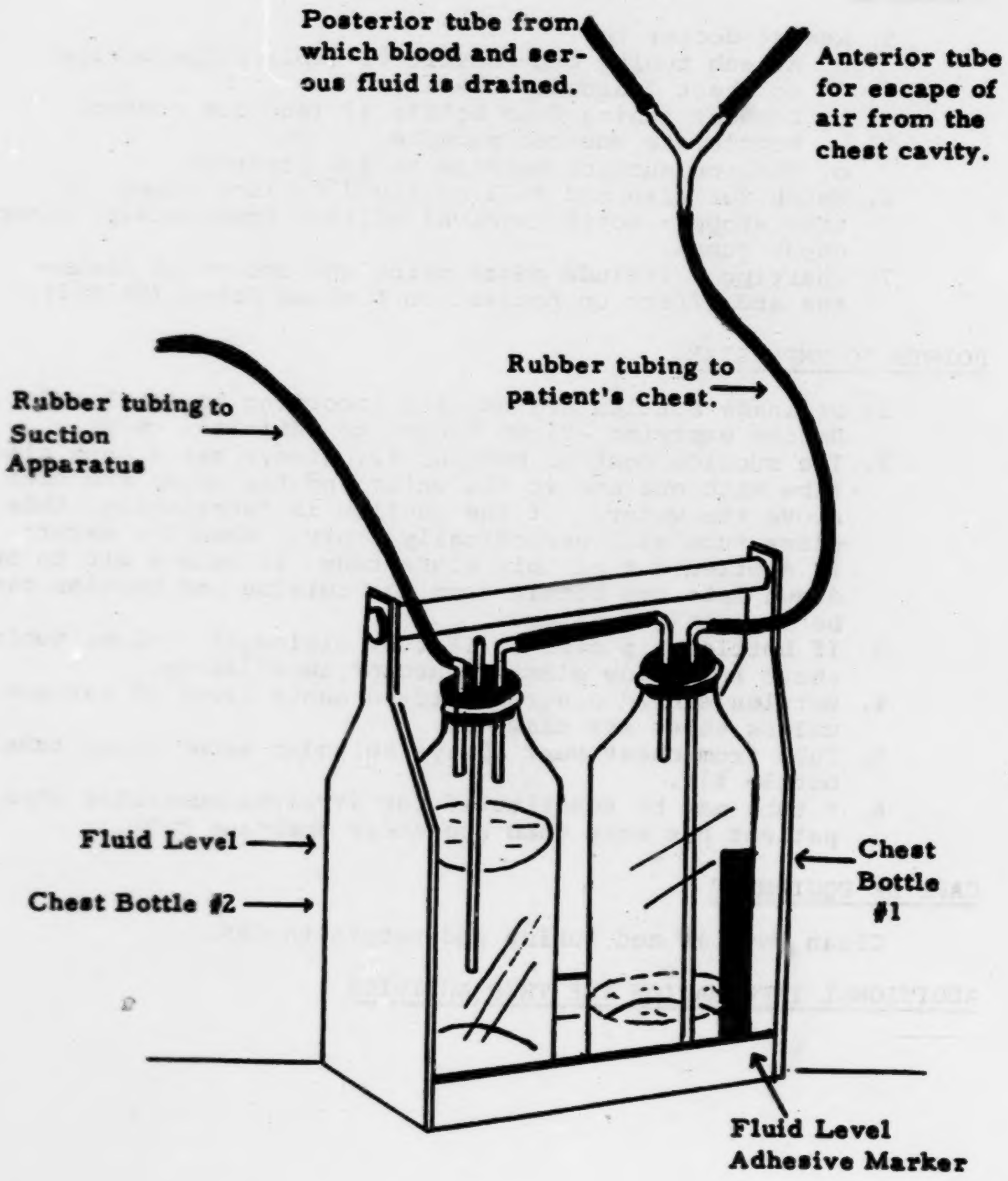
1. Drainage bottles are emptied according to local order. Before emptying, clamp tubing to patient's chest.
2. The suction control bottle, #2, always has a long glass tube with one end in the water and the other end open above the water. If the suction is functioning, this glass tube will periodically empty. When the water is emptied out of this glass tube, it causes air to be drawn into the bottle from the outside and bubbles can be seen in the water.
3. If bottles tip over or if tube dislodges - clamp tubing above and below glass connector immediately.
4. Bottles should never be lifted above level of patient unless tubes are clamped.
5. Tube from chest must always be under water (long tube, bottle #1).
6. Y tube may be substituted for straight connector when patient has more than one chest drainage tube.

CARE OF EQUIPMENT

Clean bottles and tubing and return to CSR.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

WATER-SEALED CHEST DRAINAGE


Posterior tube from which blood and serous fluid is drained.
Anterior tube for escape of air from the chest cavity.
Rubber tubing to patient's chest.
Rubber tubing to Suction Apparatus
Fluid Level
Chest Bottle #2
Chest Bottle #1
Fluid Level Adhesive Marker

COLOSTOMY IRRIGATION

PURPOSE

To cleanse the intestinal tract and promote regularity of evacuation for a patient with a colostomy.

EQUIPMENT

Irrigating can with rubber tubing and glass connector or disposable enema bag #16 or 18 or Fr. catheter or small rectal tube
Warm tap water
Protective sheet or pads
Water soluble lubricant
Two curved basins
Colostomy dressing set
Toilet paper and paper towels
Bedpan and cover

PROCEDURE

1. Wash hands.
2. Screen patient, tell him what you are going to do.
3. Assemble equipment. Take to bedside.
4. Turn patient to side of colostomy.
5. Place protective sheet or pads under patient.
6. Remove dressing.
7. Place curved basin under colostomy opening and as close to the patient as possible.
8. Fill irrigating can with solution and attach to catheter.
9. Introduce lubricated catheter about four inches into colostomy. Hold tube in place.
10. Raise irrigating can ten inches above colostomy.
11. Allow at least 250 cc. and no more than 500 cc. of solution to slowly enter the colon, then clamp the irrigating tube.
12. Remove the catheter from the colostomy, and allow the solution and feces to drain into the curved basin.
13. When curved basin under colostomy is almost filled, remove and replace it with another curved basin. Empty contents into covered bedpan.
14. When all solution has drained from colostomy, reinsert catheter and repeat process until return flow is free of fecal matter.
15. Clean area around colostomy opening and apply colostomy dressing or bag.

COLOSTOMY IRRIGATION (Continued)

PROCEDURE (Continued)

16. Remove equipment to utility room and wash hands.
17. Make patient comfortable. Leave unit clean and in order.
18. Record time, solution, character of return, and effect of the treatment on Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. If obstruction is encountered as the catheter is passed, wait a few seconds and again attempt to advance the catheter.
2. Do not force the catheter against resistence.
3. Teach and encourage patient to carry out this procedure when permitted by the medical doctor.
4. Report any pain or discomfort experienced by patient during irrigation.
5. Cleanse skin thoroughly around colostomy and apply a protective ointment.
6. Colostomy dressing should be changed frequently for the patient's comfort, to prevent odor and to prevent the skin from breaking down.
7. Procedure may take as long as one hour. Do not apply dressing until all of the solution is drained from the colostomy.

CARE OF EQUIPMENT

1. Wash equipment, rinse and return to CSR.
2. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

V

DIAGNOSTIC TESTS AND PROCEDURES

Laboratory manuals are available in most naval medical activities and should be used as references.

In activities where local manuals are not available or in cases where tests are ordered and not found in the local manual, this procedure manual may be used as a reference.

TECHNIQUE OF VENIPUNCTURE

PURPOSE

To obtain a specimen of blood for laboratory examination.

EQUIPMENT

Tray with:
  Tourniquet
  Sterile syringe - size as needed
  Sterile needles - 20 - 21 gauge, 1 1/4" length
  Alcohol sponges
  Tube for blood specimen
  Sterile 2 x 2 gauze sponge

PROCEDURE

1. Wash hands.
2. Assemble equipment.
3. Explain procedure to the patient.
4. Apply tourniquet firmly about upper arm.
5. Select a vein in arm which can be seen and easily palpated.
6. Cleanse skin with alcohol sponge.
7. Hold patient's arm extended with little or no flexion at elbow.
8. Hold syringe firmly. Enter vein with bevel of needle uppermost.
9. Withdraw blood sample.
10. Release tourniquet.
11. Place dry sponge over puncture site. Withdraw needle. Apply pressure.
12. Inject blood from syringe into proper blood tube for diagnostic procedure.

POINTS TO EMPHASIZE

1. If needle fails to enter vein, it may be withdrawn slightly. Keep point well under the skin, and again direct toward vein.
2. Report if you are unsuccessful in obtaining a specimen or entering a vein after 2 attempts. Do Not Continue.
3. Blood cannot flow into arm and fill veins if the tourniquet has been applied too tightly.
4. A blood pressure cuff with manometer may be used in place of a tourniquet.
5. A sterilized syringe and needle are used for each patient.

POINTS TO EMPHASIZE (Continued)

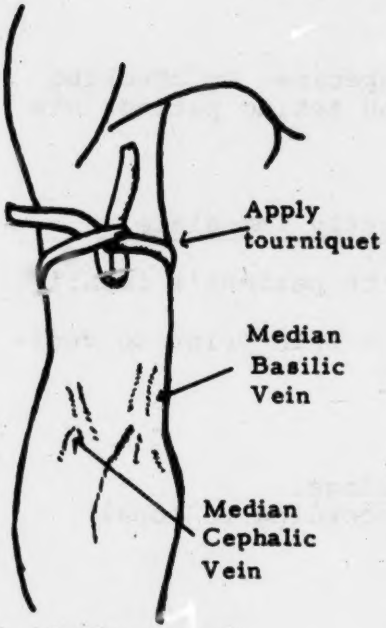
6. Identify patient before taking specimen by checking bed tag, identification band, and asking patient his name.
7. To prevent hemolysis:
   a. Use dry syringe and tube.
   b. On oxalated blood, agitate gently immediately after introducing into bottle.
8. Label each specimen container with patient's identifying data.
9. Allow alcohol to dry on patient's skin prior to venipuncture to reduce pain.

CARE OF EQUIPMENT

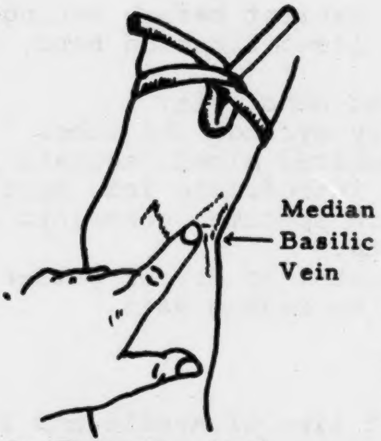
1. Break off tips of needle and syringe.
2. Dispose of needle and syringe according to local instructions.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TECHNIQUE OF VENIPUNCTURE (Continued)

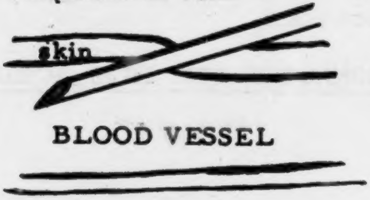

Apply tourniquet
Median Basilic Vein
Median Cephalic Vein

1. Application of tourniquet

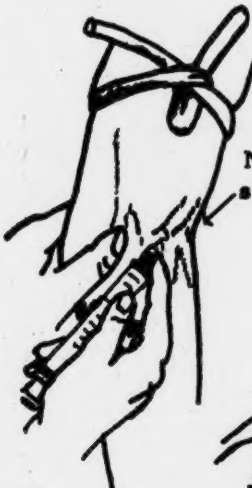

Median Basilic Vein

2. Palpation of vein

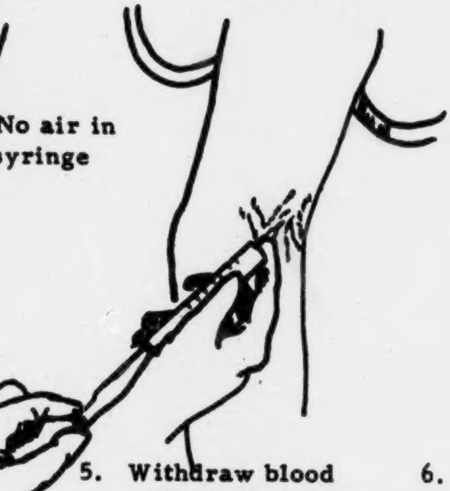
3. Application of antiseptic


skin
BLOOD VESSEL

Enlargement showing needle entering the blood vessel


No air in syringe

4. Insert the needle



5. Withdraw blood release tourniquet

6. Apply alcohol sponge remove needle and syringe

TECHNIQUE OF VENIPUNCTURE WITH VACUTAINER

PURPOSE

To obtain a specimen of blood for laboratory examination.
To obtain multiple blood specimens from one venipuncture.

EQUIPMENT

Tray with
  Tourniquet
  Vacutainer holder
  Vacutainer (according to test(s) required)
  Alcohol sponges
  Two way vacutainer needles
  Sterile 2 x 2 gauze sponge

PROCEDURE

1. Wash hands.
2. Assemble equipment.
3. Explain procedure to the patient.
4. Apply tourniquet firmly about the upper arm.
5. Select a vein in arm which can be easily seen and palpated.
6. Cleanse skin with alcohol sponge.
7. Hold patient's arm extended with little or no flexion at elbow.
8. Hold vacutainer firmly. Enter vein with bevel of needle uppermost.
9. Push proper blood container firmly into opposite needle end for proper suction. Withdraw blood sample as needed.
    a. This step is repeated at this point when multiple specimens are required.
10. Release tourniquet.
11. Place dry sponge over puncture site. Withdraw needle. Apply pressure to site of venipuncture.

POINTS TO EMPHASIZE

1. If needle fails to enter vein, it may be withdrawn slightly. Keep point well under the skin and again direct toward vein.
2. Report if you are unsuccessful in obtaining a specimen or entering a vein after two attempts. Do Not Continue.
3. Blood cannot flow into arms and fill veins if the tourniquet has been applied too tightly.
4. A blood pressure cuff with manometer may be used in place of a tourniquet.
5. A sterile vacutainer needle is used for each patient.
6. Allow alcohol to dry on skin prior to venipuncture to reduce pain.

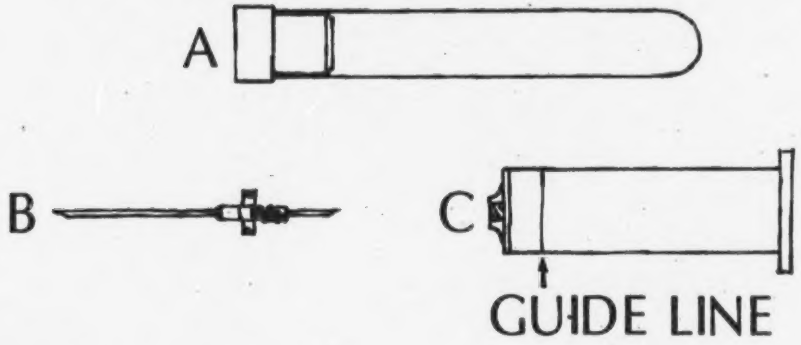
TECHNIQUE OF VENIPUNCTURE WITH VACUTAINER (Continued)

CARE OF EQUIPMENT

1. Break off tip of needle.
2. Dispose of needle according to local instruction.

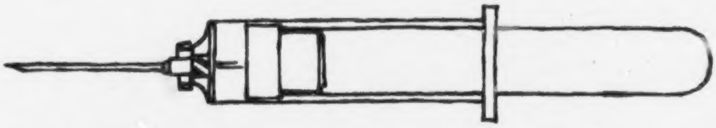
ADDITIONAL INFORMATION FOR THIS ACTIVITY

VACUTAINER



PARTS

A. EVACUATED GLASS TUBE WITH RUBBER STOPPER
B. DOUBLE POINTED NEEDLE
C. PLASTIC HOLDER



TO ASSEMBLE VACUTAINER

1. THREAD NEEDLE INTO HOLDER
2. PLACE TUBE IN HOLDER WITH NEEDLE TOUCHING STOPPER
3. PUSH TUBE FORWARD UNTIL TOP OF STOPPER MEETS GUIDE LINE

COLLECTION OF SPECIMENS
BLOOD CULTURE

(Using Vacutainer Bottle)

PURPOSE

To detect the presence of organisms in the blood.

EQUIPMENT

Blood collecting unit especially designated to go with Vacutainer Culture Bottle
Two Vacutainer Culture Bottles
2 x 2 sponges, sterile
Hemostat
Skin preparation solution as prescribed
Bacteriology form for aerobic and anaerobic specimens

PROCEDURE

1. Wash hands.
2. Explain procedure to patient.
3. Prep site with solution prescribed by local policy.
4. Assemble vacutainer as directed.
5. Be sure tubing from vacutainer to needle is clamped.
6. Execute venipuncture.
7. Remove or have assistant remove cap from blood culture bottle (outer cap only).
8. Remove cap from short needle.
9. Insert needle into blood culture bottle for anaerobic specimen.
10. Lower bottle below level of patient, release clamp and allow 5 cc. of blood to enter blood culture bottle.
11. Clamp tubing, have assistant insert needle into second blood culture bottle. Release clamp and allow 5 cc. of blood to drain into second bottle.
12. Release tourniquet.
13. Place dry sponge over puncture site.
14. Remove needle from arm, let air into bottle for aerobic specimen.
15. Submit specimens with properly labelled chits to bacteriology laboratory immediately.

POINTS TO EMPHASIZE

1. Contamination of the blood from skin, apparatus, container of air will render this test ineffective.
2. Tourniquet must be tight enough to obstruct venous flow but not cause discoloration of extremity.
3. If patient is on antibiotic therapy, drugs must be listed on bacteriology chit.

COLLECTION OF SPECIMENS (Continued)
BLOOD CULTURE

(Using Vacutainer Bottle)

CARE OF EQUIPMENT

1. Replace equipment.
2. Break off tip of needle.
3. Discard disposable needle and tubing according to local instructions.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS
BLOOD
BROMSULPHALEIN TEST

PURPOSE

To determine liver function.

EQUIPMENT

BSP dye
Two sterile syringes; 10 cc. and 18 gauge needles
Tourniquet
One sterile test tube without anticoagulant
SF 546, Blood Chemistry

PROCEDURE

1. Explain procedure. Tell patient what he is to do.
2. Instruct patient to:
   a. Take nothing by mouth after 2400 hours.
   b. Delay breakfast until after the test.
3. Weigh patient at 0600 and divide weight by 2.2 to determine the patient's weight in kilograms. The amount of dye to be injected by the medical officer is calculated on the basis of the patient's weight in kilograms. (5 mg. of dye per kilogram of body weight.)
4. Have dye ready for medical officer. Record time given on SF 546 and record procedure on Nursing Notes (SF 510).
5. Draw blood sample from opposite arm of injection 45 minutes following injection of dye.

POINTS TO EMPHASIZE

1. Use separate syringe and needle for injection and taking blood samples.
2. Amount of dye injected is determined by patient's weight in kilograms. The dosage is verified by the medical officer injecting the dye.

CARE OF EQUIPMENT

1. Break tips of needles and syringes.
2. Discard disposable needle and tubing according to local instructions.

COLLECTION OF SPECIMENS (Continued)
BLOOD
BROMSULPHALEIN TEST

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS
BLOOD AND URINE
GLUCOSE TOLERANCE TEST

PURPOSE

To assist in detection and diagnosis of diabetes mellitus or other liver disturbances.

EQUIPMENT

NPO sign
Tray containing:
- Five sterile 10 cc. syringes
- Five sterile 20 or 21 gauge, 1 1/4" length needles
- Tourniquet
- Alcohol sponges
- Glucose preparation as ordered
- Five (oxalate) gray top tubes with labels
- Five urine specimen bottles with labels
- Rubber bands
- Standard Form 550, Urinalysis
- Standard Form 546, Blood Chemistry

PROCEDURE

1. Explain procedure. Tell patient what he is to do.
2. Patient is to have nothing by mouth after 1900 the day preceding test.
3. A fasting blood specimen is drawn and a urine sample is collected for a control specimen upon arising. Label Specimen #1.
4. Patient drinks a glucose and water diet containing 1 gram of glucose per kilogram of body weight.
5. Collect urine specimens and 5 cc. blood specimens after ingestion of glucose, as follows:
   a. Specimen #2 - one half hour interval.
   b. Specimen #3 - one hour interval.
   c. Specimen #4 - two hours interval.
   d. Specimen #5 - three hours interval.
6. Hold all urine and blood specimens until test is completed. Send to laboratory marked with appropriate forms.
7. Record procedure on the Nursing Notes (SF 510).

POINTS TO EMPHASIZE

1. Label specimen bottle and tubes in advance with patient's identification and specimen number. Record time specimen is obtained on appropriate label.

COLLECTION OF SPECIMENS (Continued)
BLOOD AND URINE
GLUCOSE TOLERANCE TEST (Continued)

POINTS TO EMPHASIZE (Continued)

2. Patient may drink water after the one-hour specimen has been collected.
3. Ambulatory patients may go to the laboratory for entire test.

CARE OF EQUIPMENT

1. Break off tips of needle and syringes.
2. Discard needles and syringes according to local instruction.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS
URINE

Single Clean Specimen

PURPOSE

To obtain a specimen of urine for routine and miscroscopic examination

EQUIPMENT

Clean urinal or bedpan
Urine specimen bottle with cap
Rubber band
Standard Form 550, Urinalysis

PROCEDURE

1. Tell patient what he is to do.
2. Have patient void into clean bedpan or urinal.
3. Pour sample (120-155 cc.) into specimen bottle. Cap.
4. Wrap request around bottle. Hold in place with rubber band.
5. Send specimen to laboratory with SF 550.

Single Sterile Specimen

PURPOSE

To obtain specimen of urine for bacteriological and other examinations.

EQUIPMENT

Catheterization tray
Sterile gloves
Sterile specimen bottle
Rubber band
Standard Form 550, Urinalysis

PROCEDURE

1. Catheterize patient.
2. Collect urine directly from catheter into sterile bottle. Cover with sterile gauze or sterile cap.
3. Wrap request around bottle. Hold in place with rubber band.
4. Send specimen to laboratory.

MIDSTREAM OR CLEAN-CATCH URINE

PURPOSE

To obtain a clean specimen of urine for laboratory analysis.

EQUIPMENT

Sterile urine bottle and cap
4 x 4 gauze sponges, sterile
Disinfectant as ordered by local command

PROCEDURE (MALE)

1. Instruct patient to:
   a. Wash penis using 4 x 4s and disinfectant ordered. (Cleanse well around foreskin and meatus.)
   b. Void small amount of urine into toilet and then void directly into sterile bottle.
2. Place sterile cap on bottle.
3. Wrap request around bottle and secure with rubber band.
4. Send specimen to laboratory.

PROCEDURE (FEMALE)

1. Instruct patient to:
   a. Wash genitalia using 4 x 4s and disinfectant.
   b. During voiding hold labia apart.
   c. Void small amount of urine into toilet and then void directly into sterile bottle.
2. Place sterile cap on bottle.
3. Wrap request around bottle and secure with rubber band.
4. Send specimen to laboratory.

POINTS TO EMPHASIZE

1. Discard 4 x 4s into waste receptacle.
2. Thorough cleansing of external genitalia is essential.
3. Patient must void first portion of specimen into toilet.
4. Urine specimens should be sent to the laboratory as soon as possible because urinary sediments are greatly altered by time.

COLLECTION OF SPECIMENS (Continued)
URINE

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
URINE

24 - HOUR COLLECTION -- QUANTITATIVE SPECIMEN

PURPOSE

To obtain all urine produced by the kidney over a 24-hour period of time for the purpose of studying kidney function.

EQUIPMENT

Urinal or bedpan
Large container and cover
Shipping tag
Standard Form 550, Urinalysis

PROCEDURE

1. Label bottle - include patient's name, rate, date, ward, type of specimen.
2. Explain procedure. Tell patient what he is to do.
3. Ask patient to void at 0600. Discard specimen.
4. Collect all urine voided for 24 hours in bottle.
5. Ask patient to void at 0600 following morning. Add to bottle. If unable to void, obtain order for catheterization.
6. Send entire specimen to laboratory with SF 550.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
URINE
REAGENT TEST FOR SUGAR

PURPOSE

To determine the amount of sugar, if any, contained in the patient's urine.

CLINITEST

EQUIPMENT

Clinitest Reagent Tablet
Bedpan or urinal
Test tube and holder
Medicine dropper
Clinitest Color Chart

PROCEDURE

1. Ask patient to void.
2. Place 5 drops of urine in clean test tube with medicine dropper. Rinse dropper.
3. Add 10 drops of water to test tube.
4. Place test tube in holder as chemical reaction causes heat.
5. Drop in one Clinitest Tablet. Watch solution boil.
6. Wait 15 seconds after boiling stops. Gently shake tube.
7. Hold test tube next to color chart and compare:
    a. All shades of blue. . . . . Negative for sugar
    b. Green. . . . . .1 plus for sugar
    c. Olive tan. . . . . .2 plus for sugar
    d. Orange. . . . . 3 plus for sugar
    e. Brown. . . . . .4 plus for sugar
8. Record result of test on Nursing Notes (SF 510) and/or Diabetic Flow sheet.

POINTS TO EMPHASIZE

1. Clinitest Color Chart must be used with Clinitest Tablets.
2. Do not touch Clinitest Tablets with fingers, for moisture initiates a chemical reaction producing heat.
3. Keep cap of bottle of Clinitest Tablets tightly closed to prevent decompensation.
4. A double voided may be ordered. This refers to a specimen obtained 30 minutes after the patient empties his bladder.

COLLECTION OF SPECIMENS (Continued)
URINE
REAGENT TEST FOR SUGAR (Continued)

CLINISTIX

EQUIPMENT

Bedpan or urinal
Clinistix
Clinistix Color Chart

PROCEDURE

1. Ask patient to void.
2. Dip test end of strip into urine and remove.
3. Wait exactly one minute.
4. Compare both sides of strip with Clinistix Color Chart:
    a. No blue color - negative for sugar
    b. Light blue - 1 plus for sugar
    c. Medium blue - 2 plus for sugar
    d. Dark blue - 3 plus for sugar
5. Record results of test on Nursing Notes (SF 510) and/or Diabetic Flow Sheet.

TES-TAPE

EQUIPMENT

Bedpan or urinal
Tes-Tape
Tes-Tape Color chart

PROCEDURE

1. Ask patient to void.
2. Cut one and one-half inch (1 1/2) strip from Tes-Tape roll.
3. Dip Tes-Tape strip in urine and remove.
4. Wait exactly one minute.
5. Compare with Tes-Tape Color Chart on side of container.
    a. Yellow - negative
    b. Light green - 1 plus for sugar
    c. Olive green - 2 plus for sugar
    d. Medium green - 3 plus for sugar
    e. Dark green - 4 plus for sugar
6. Record result of test on Nursing Notes (SF 510) and/or Diabetic Flow Sheet.

COLLECTION OF SPECIMENS (Continued)
URINE
REAGENT TEST FOR SUGAR (Continued)

POINTS TO EMPHASIZE

Special color chart for each reagent must be used.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

URINE
REAGENT TEST FOR ACETONE
ACETEST

PURPOSE

To determine the amount, if any, of acetone contained in the urine.

EQUIPMENT

Bedpan or urinal
Medicine dropper
Acetest Reagent Powder
Filter paper or paper towel
Color Chart

PROCEDURE

1. Ask patient to void. Discard specimen.
2. Ask patient to void one-half hour later. Save specimen for test.
3. Place small amount of Acetest Powder on filter paper or on paper towel. (One Acetest Tablet may be used.
4. Place one or two drops of urine on Acetest Powder/Tablet. Wait 30 seconds.
5. No change in color indicates a negative result; lavender or deep purple indicates a positive test.
6. Record result of test on Nursing Notes (SF 510) and/or Diabetic Flow Sheet.

CARE OF EQUIPMENT

Discard specimen; clean and return equipment to proper place.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
URINE
UROBILINOGEN

PURPOSE

To determine the amount of bile (if any) in the urine.

EQUIPMENT

Urine specimen bottle and cap
Standard Form, 550 Urinalysis

PROCEDURE

1. Tell patient what he is to do.
2. Have patient void at specified time. Discard specimen.
3. Instruct patient to drink a glass of water.
4. Collect specimen two hours later.
5. Send to laboratory immediately with SF 550.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
URINE
ADDIS SEDIMENT COUNT

PURPOSE

To calculate the total urinary sediment in a twelve hour specimen.

EQUIPMENT

Wide-mouth bottle from laboratory
Standard Form 550, Urinalysis

PROCEDURE

1. Explain procedure. Tell patient what he is to do.
2. Patient may have usual breakfast.
3. Withhold fluids in any form for next 24 hours. May have diet except fluids and fruit.
4. Ask patient to void at 2000 hours. Discard specimen. Record time bladder was emptied on laboratory chit. Ask patient not to void for next 12 hours. If he must void during this period, urine must be saved.
5. Ask patient to void into container at 0800 the next morning and record on the label the exact time of voiding.
6. Cover container and send specimen to laboratory with request, specifying name of test and exact time of collection.

POINTS TO EMPHASIZE

1. The time interval is important.
2. A 12 hour night specimen is the requirement.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
URINE
FISHBERG CONCENTRATION TEST

PURPOSE

To determine the specific gravity of urine.

EQUIPMENT

Three urine specimen bottles with labels
Standard Form 548, Renal Function

PROCEDURE

1. Explain procedure. Tell patient what he is to do.
2. On day before test:
   a. Patient may have usual lunch. Dry evening meal.
   b. Withhold all fluids for 17 hours prior to collecting the first specimen.
   c. Nothing by mouth after 2400 hours.
   d. Have patient void before retiring. This specimen and any urine voided during night is discarded.
3. Collect specimen #1 at 0500, while patient is in bed. Record time of voiding on specimen label.
4. Collect specimen #2 at 0600 while patient is in bed. Record time of voiding on label.
5. Ask patient to get out of bed and move about ward for one hour.
6. Collect specimen #3 at 0700. Record time of voiding on label.
7. Send specimens to laboratory with SF 548.
8. Serve patient breakfast.

POINTS TO EMPHASIZE

Patient remains in bed until after Specimen #2 is collected.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
URINE
24 HOUR URINE FOR VANLMANDELU ACID (Continued)
(VMA)

PURPOSE

A screening test to assist the doctor in the diagnosis of Pheochromorytoma. The major symptom of this disease is hypertension.

EQUIPMENT

24 hour urine container with acidic preservative.
(Obtain container from laboratory)
Standard Form 548, CHEM III (Urine)

PROCEDURE

1. Explain procedure. Tell patient when and what he is to do.
2. All medications are withheld for 48 hours before beginning the urine collection and during the collection period.
3. VMA diet 48 hours prior to and during collection of urine. This is a Regular Diet which excludes the following: NO coffee, tea, chocolate, bananas, avocados, nuts, vanilla, or citrus fruits.
4. Have patient void on morning of test before breakfast. Discard this specimen. Record time of voiding.
5. All urine during the next 24 hours is collected in special container with preservative.
6. During the collection period the bottle containing the urine must be protected from sunlight.
7. At the end of the collection period the entire 24 hour specimen is sent to the laboratory properly labeled.

POINTS TO EMPHASIZE

1. Invalid test results will be obtained if dietary and medication restrictions are not followed.
2. Care should be taken to avoid contact of preservative solution with skin since it is an acid.

COLLECTION OF SPECIMENS (Continued)
URINE
24 HOUR URINE FOR VANLMANDELU ACID (Continued)
(VMA)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

URINE
PHENOLSULFONPHTHALEIN EXCRETION TEST
PSP TEST

PURPOSE

To determine kidney function.

EQUIPMENT

Sterile tuberculin syringe
Sterile 20 or 21 gauge, 1 1/4" length needle
Alcohol sponges
Ampule of Phenolsulfonphthalein Dye (6 mg.)
Tourniquet
Four labeled urine specimen bottles and caps
Standard Form 548, Renal Function

PROCEDURE

1. Tell patient what he is to do.
2. Give patient two glasses of water one hour before test. Instruct him not to void.
3. Draw up one cc. of PSP dye into tuberculin syringe.
4. Note exact time the medical officer injects dye intravenously.
5. Exactly 15 minutes after dye has been injected, have patient void completely emptying his bladder. Save entire amount. Label 15 minute specimen.
6. Have patient void in 30, 60 and 120 minutes after dye injection. Save all urine voided each time. Label 30 minute, 60 minute, 120 minute specimens with exact time of voiding. Patient may have one glass of water after the 60 minute specimen is collected, if necessary.
7. Send specimens and request to laboratory.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
SPUTUM

PURPOSE

To collect a specimen of sputum for laboratory analysis.
To determine causative organisms in respiratory diseases.

EQUIPMENT

Sputum jar with cover
Rubber band
Standard Form 554, Bacteriology

PROCEDURE

Single Specimen

1. Administer oral hygiene or instruct patient to do so.
2. Instruct patient to cough deeply and to expectorate directly into jar.
3. Label specimen jar with patient's name and ward.
4. Attach request to covered jar with rubber band.
5. Send specimen to laboratory.

24 Hour Specimen

1. Instruct patient as to what he is to do:
   a. Expectorate all sputum directly into jar each time he coughs deeply.
   b. Cover jar each time he expectorates.
2. Start and stop collection of sputum at a definite time - 0600 - 0600 hours.
3. Send properly labeled specimen to laboratory with request chit upon completion of test.

POINTS TO EMPHASIZE

1. Instruct patient:
   a. Not to expectorate saliva into jar.
   b. To keep jar covered.
2. Indicate on SF 554 examination desired and submit request in duplicate if smear and culture is requested.
3. All 24-hour collections should begin and end at a definite time and the bottle or cover should be so marked.

COLLECTION OF SPECIMENS (Continued)
SPUTUM

ADDITIONAL INFORMATION FOR THIS ACTIVITY

GASTRIC ANALYSIS

SINGLE FASTING SPECIMEN

PURPOSE

To remove gastric secretions for diagnostic studies.

EQUIPMENT

Levin tube, rubber/plastic
Basin cracked ice (omit for plastic tube)
Water soluble lubricant
Protective sheet or pad
Clean test tubes or glass specimen jars
20 or 30 cc. syringe
Curved basin
Rubber band
Standard Form 547, Gastric Analysis
Nothing by Mouth (NPO) sign

PROCEDURE

1. Explain procedure. Tell patient what he is to do.
2. Nothing by mouth after 2400 hours.
3. Place patient in sitting position to facilitate passing of tube.
4. Lubricate tip of tube with small amount of water or water soluble lubricant. Pass tube gently into patient's nostril and into nasopharynx.
5. Allow patient small piece of ice to suck on if he wishes. Tell patient to swallow while tube is being passed into stomach.
6. Observe patient's breathing and voice to tell whether tube is passing into the correct canal. If breathing or speaking becomes difficult, withdraw tube immediately.
7. When tube is in the stomach, withdraw specimen with syringe. Place specimen in tube or jar and label "Fasting".
8. The medical officer may inject alcohol or histamine through the tube into the stomach after the fasting specimen is withdrawn.
9. Continue to collect specimens every 15 minutes for one and one-half hours after the initial fasting specimen.
10. Remove Levin tube. Make patient comfortable.
11. Label each test tube or specimen jar with name of patient and time collected. Send specimen to laboratory with request.
12. Patient may have his breakfast upon completion of test.

COLLECTION OF SPECIMENS (Continued)
GASTRIC ANALYSIS

SINGLE FASTING SPECIMEN (Continued)

POINTS TO EMPHASIZE

Do not use mineral oil to lubercate tip of Levin tube.

CARE OF EQUIPMENT

1. Wash tube and syringe and return to CSR.
2. If plastic Levin tube is used, discard it.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
FECES

PURPOSE

To obtain a sample of feces for diagnostic study.

EQUIPMENT

Clean bedpan
Screw capped specimen jar
Two tongue blades
Rubber band
Standard Form 552, Feces

PROCEDURE WHEN TESTING FOR OVA AND PARASITES

1. Collect specimen in clean bedpan.
2. Take bedpan to utility room.
3. Remove approximately one ounce of feces from pan with tongue blades. Place in jar. Cover.
4. Attach request to jar and secure with rubber band.
5. Send specimen to laboratory immediately with SF 552.

PROCEDURE WHEN EXAMINING FOR OCCULT BLOOD

1. Patient is placed on a meat-free diet two days before specimen is collected.
2. Collection procedure is same as above.

PROCEDURE OCCULT BLOOD - ALTERNATE

1. Obtain stock MF (merthiolate formaldehyde) tube from laboratory.
2. Place fecal sample (about size of a pea) in tube.
3. Insert stopper in tube. Send to laboratory with SF 552 in duplicate.

PROCEDURE WHEN EXAMINING FOR AMOEBA

1. Remove feces from pan with tongue blades. Place in jar and cover.
2. Send warm specimen with request to laboratory immediately. If unable to send specimen immediately, place jar in basin of warm water.
3. Record on SF 552 the time the specimen was passed.

POINTS TO EMPHASIZE

Specimen to be examined for amoeba must be kept warm and sent to laboratory immediately.

COLLECTION OF SPECIMENS (Continued)
FECES

CARE OF EQUIPMENT

1. Discard tongue blades in paper container for burning in incinerator.
2. Clean and sanitize bedpan.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)

GUIAC TEST

PURPOSE

To test stool specimen for blood.

EQUIPMENT

Three bottles with droppers containing:
  (1) Acetic acid solution 10%
  (2) Saturated solution of guiac
  (3) Hydrogen peroxide 3%
Clean glass slide
Application stick
Watch with second hand

PROCEDURE

1. Place two drops of each solution on glass slide. Do not mix solutions.
2. With applicator stick place small amount of feces on glass slide and mix with solutions.
3. Read results within 30 seconds.
4. A blue-green color is reported as positive; otherwise, the report is negative.
5. Record results on Nursing Notes (SF 510) and/or flow sheet.

POINTS TO EMPHASIZE

1. Solutions must be fresh.
2. Do not mix solutions until after feces has been added.

CARE OF EQUIPMENT

1. Discard applicator and slide.
2. Replace equipment.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
RECTAL SWAB

PURPOSE

To obtain specimen for detection of worms.

EQUIPMENT

Rectal swab in broth obtained from laboratory

PROCEDURE

1. Explain procedure to patient if old enough to comprehend.
2. Moisten applicator with warm broth and insert into anus. Rotate to obtain specimen from rectal wall.
3. Place applicator in test tube and take to laboratory with completed SF 554 immediately.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
DISCHARGES FROM WOUNDS OR CAVITIES
SMEAR

PURPOSE

To obtain a sample of wound discharges for laboratory examination.

EQUIPMENT

Sterile slides
Sterile applicators
Rubber bands - 2
Standard Form 554, Bacteriology

PROCEDURE

1. Tell patient what you are going to do.
2. Open package of slides, taking care not to contaminate them.
3. Take sample of discharge from wound using a sterile applicator.
4. Spread discharge lightly in center of slide.
5. Repeat for second slide. Discard applicators in paper bag for disposition in incinerator.
6. Place slides together so that specimens on each slide are in contact.
7. Put rubber bands around both slides, thus fastening them.
8. Take to laboratory immediately with request form.

POINTS TO EMPHASIZE

Indicate on SF 554 the examination desired.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLLECTION OF SPECIMENS (Continued)
DISCHARGES FORM WOUNDS OR CAVITIES
CULTURE

PURPOSE

To collect specimen for laboratory analysis.

EQUIPMENT

Sterile culture tube containing a sterile cotton applicator, disposable
Standard Form 554, Bacteriology
For throat culture obtain special tube with special media from laboratory

PROCEDURE

1. Tell patient what you are going to do.
2. Remove cotton applicator from the tube; do not contaminate tip or stem of applicator.
3. Swab area to be cultured with applicator.
4. Replace applicator in tube and secure screw cap.
5. Take to laboratory immediately with completed SF 554.

PRECAUTION

Cultures must be taken to the laboratory immediately after being collected and handed to laboratory personnel. A dried out specimen is of no value.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION FOR RADIOLOGICAL STUDIES
ANGIOCARDIOGRAPHY

PURPOSE

To visualize by x-ray the heart and great blood vessels after a contrasting media is introduced through a vein.

EQUIPMENT

NPO sign
Preoperative medication as ordered
SF 522, Authorization Permit

PROCEDURE

1. Test dose of contrast media is given by Ward Medical Officer day prior to study.
2. Patient is given nothing by mouth after 2400 providing the examination is scheduled for the following morning.
3. Check patient's chart for signed permit (SF 522) and completed test results (CBC, urinalysis, chest x-ray).
4. Notify the x-ray department if patient has any known allergies.
5. Give preoperative medication as ordered.

AORTOGRAPHY AND ARTERIOGRAPHY

PURPOSE

To visualize by x-ray the aorta and arteries after a contrasting media has been injected.

EQUIPMENT

Same as for angiocardiography
Skin prep set for aortography

PROCEDURE

1. Skin preparation for aortography - prepare back from scapulae to sacrum.
2. Procedure is the same as for angiocardiography.
3. Give medication as ordered.

AORTOGRAPHY AND ARTERIOGRAPHY (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION FOR RADIOLOGICAL STUDIES
ARTERIOGRAPHY (CEREBRAL)

PURPOSE

To visualize by x-ray the major vessels of the brain after a contrasting media has been injected, usually into the common carotid artery.

EQUIPMENT

NPO sign
Medication as ordered
Standard Form 519, Radiographic Report
Standard Form 522, Authorization Permit

PROCEDURE

1. Test dose of contrast media is given by Ward Medical Officer day prior to study.
2. Check with patient regarding allergies and notify the medical officer if allergies are reported.
3. Check patient's chart for signed permit SF 522.
4. Patient is given nothing by mouth after 2400.
5. Give preoperative medication as ordered one-half hour before sending patient to x-ray.
6. Completed SF 519A should accompany the patient.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION FOR RADIOLOGICAL STUDIES
BRONCHOGRAM

PURPOSE

To visualize by x-ray the outlines of the bronchial tubes and their branches after a contrasting media is introduced through a cannula or an intratracheal catheter into the air passages.

EQUIPMENT

NPO sign
X-ray films
Standard Form 516, Operative Report
Standard Form 517, Anesthesia Report
Standard Form 522, Authorization Permit
Medication as ordered

PROCEDURE

1. Test dose of contrast media is given by Ward Medical Officer day prior to study.
2. Omit meal directly prior to examination:
   a. Nothing by mouth after 2400 if examination is to be done in the morning.
   b. Light liquid breakfast, no lunch if examination is scheduled to be done in the afternoon.
3. Include in patient's chart:
   a. One Operative Report, SF 516.
   b. Two Anesthesia Reports, SF 517 with carbon
   c. One Authorization Permit, 522. Signed.
4. Give medication as ordered.
5. Send patient to the x-ray department with his chart and x-ray films at appointed time.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION FOR RADIOLOGICAL STUDIES

CHOLECYSTOGRAPHY

(Gallbladder Series)

PURPOSE

To prepare the patient for radiographic visualization of the common bile duct and gallbladder.

EQUIPMENT

NPO Sign
Radiopaque media

PROCEDURE

1. Patient is given supper of dry toast, jelly, fruit and coffee or tea the evening preceding the examination.
2. Following the evening meal the patient is given six Telopaque tablets and instructed to take one every five minutes. (If other radiopaque media is used give as directed.)
3. Only water, clear tea or black coffee may be taken after ingestion of tablets.
4. Withhold breakfast on day of examination.
5. Send patient to x-ray department at scheduled time.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION FOR RADIOLOGICAL STUDIES
GASTROINTESTINAL SERIES

PURPOSE

To prepare the patient for diagnostic x-rays of the upper gastrointestinal tract.

EQUIPMENT

NPO sign

PROCEDURE

1. When examination is ordered, send Standard Form 519, Radiographic Report, to x-ray department for appointment.
2. Evening preceding the examination.
   a. Liquids may be taken after the evening meal until 2400. Nothing by mouth after 2400.
   b. Cathartic or enema is given before bedtime if ordered.
   c. No smoking or chewing gum after 2400.
3. On the day of the examination:
   a. Send patient to x-ray department at scheduled time - usually in the early morning.
   b. Noon meal and fluids are withheld until x-ray department confirms that no further x-rays are to be taken.
   c. Cathartic is given after noon meal is ordered.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION OF RADIOLOGICAL STUDIES

BARIUM ENEMA

PURPOSE

To prepare the patient for a diagnostic x-ray of the lower gastro-intestinal tract.

EQUIPMENT

NPO sign

PROCEDURE

1. When examination is ordered, send Standard Form 519A, Radiographic Report, to the x-ray department for an appointment.
2. Day preceding the examination:
   a. Patient is to have nothing but low residue fluids after noon meal.
   b. Cathartic is given after noon meal if ordered.
   c. Cleansing enema is given at bedtime.
3. On the day of the examination:
   a. Enemas at 0600 until returns are clear.
   b. Send patient to x-ray department at scheduled time.
   c. When examination is completed a cathartic is given, if ordered.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION OF RADIOLOGICAL STUDIES
INTRAVENOUS PYELOGRAM

PURPOSE

To visualize by x-ray the kidneys after a contrasting media has been injected intravenously.

EQUIPMENT

NPO sign
Standard Form SF 522, Authorization Permit

PROCEDURE

1. When examination is ordered, send Standard Form 519A, Radiographic Report, to the Urology Clinic for appointment.
2. Check patient's chart for signed permit, SF 522.
3. Test dose of contrast media is given by Ward Medical Officer day prior to study.
4. On evening preceding the examination:
   a. Give cathartic or other medication if ordered.
   b. Patient is instructed to take nothing by mouth after 2400.
5. On the morning of the examination, send patient to Urological x-ray department with chart at specified time.

RETROGRADE PYELOGRAM/CYSTOGRAPHY

PURPOSE

To visualize the bladder and ureters after a contrasting media has been introduced through the urethra.

PROCEDURE

1. Patient may have a light breakfast.
2. Force fluids prior to examination.
3. Send to Urological x-ray department with chart at specified time.
4. Standard Form 522, Authorization Permit, is required for this test.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION FOR RADIOLOGICAL STUDIES
MYELOGRAM

PURPOSE

To visualize by x-ray the spinal canal after contrasting media is injected into the canal by means of a lumbar puncture.

EQUIPMENT

Skin prep set
Standard Form SF 522, Authorization Permit

PROCEDURE

1. When examination is ordered, send SF 519A, Radiographic Report, to the x-ray department for an appointment.
2. Test dose of contrast media is given by Ward Medical Officer day prior to study.
3. Check patient's chart for signed permit (SF 522).
4. If examination is to be done in the morning, the patient may have a light breakfast.
5. If examination is to be done in the afternoon, the patient may have a light lunch.
6. Shave lumbar area.
7. Give medication as ordered.
8. Send patient to x-ray on call with chart and previous x-rays.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

PREPARATION FOR RADIOLOGICAL STUDIES
PNEUMOENCEPHALOGRAM

PURPOSE

To visualize by x-ray the cerebrospinal canal, and related structures of the brain and spinal cord.

EQUIPMENT

NPO sign
Standard Form SF 522, Authorization Permit

PROCEDURE

1. When examination is ordered, send SF 519A, Radiographic Report, to the x-ray department for an appointment.
2. Check patient's chart for signed permit (SF 522).
3. Patient is given nothing by mouth after 2400 the evening preceding the examination.
4. The day of the examination, give medication as ordered or when notified by x-ray department.
5. The procedure is usually done in the x-ray department.
6. Upon return of patient to the ward, carry out the medical officer's orders as to patient's activity.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

BRONCHOSCOPY

PURPOSE

To directly view the respiratory tract.
To obtain tissue for biopsy.
To obtain pleural secretions for study.
To remove foreign bodies.

EQUIPMENT

NPO sign
X-ray films
Standard Form 522, Authorization Permit
Standard Form 515, Tissue Examination
Standard Form 516, Operative Report
Standard Form 517, Anesthesia Report
Two Standard Forms 554, Bacteriology
Medications as ordered

PROCEDURE

1. Omit meal directly prior to examination:
   a. Nothing by mouth after 2400 if examination is to be done in the morning.
   b. Liquids for breakfast and no lunch if examination is scheduled to be done in the afternoon.
2. Include in patient's chart:
   a. One Tissue Examination Sheet, SF 515.
   b. Two Anesthesia Reports, SF 517 with carbon.
   c. One Operative Report, SF 516.
   d. Two Bacteriology Reports, SF 554.
   e. Signed Authorization Permit, SF 522.
3. Give medication as ordered.
4. Send patient with his chart and x-ray films to operating room or bronchoscopy department when called or ordered.

POINTS TO EMPHASIZE

1. Nothing by mouth after examination until all sensation has returned to patient's throat.
2. No smoking until sensation returns to patient's throat.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

T-3, T-4 TEST

PURPOSE

To determine the level of thyroid hormone, thyroxin, in the patient's circulating blood stream.

EQUIPMENT

NPO sign
Sterile syringe, 10 cc.
Sterile needle - 20-21 gauge, 1 1/4" length
Blood tube, red top
Standard Form 549, Hematology

PROCEDURE

1. Nothing by mouth after 2400.
2. On the morning of the test, send patient to laboratory if ambulatory or execute venipuncture on ward.
3. Draw 10 cc. blood and place in red top blood tube.
4. Send tube and Standard Form 549 to laboratory immediately.
5. Patient may have breakfast following venipuncture.

POINTS TO EMPHASIZE

1. Clotted blood is necessary for this test.

CARE OF EQUIPMENT

1. Break off tip of needle and syringe. Dispose of syringe and needle according to local instruction.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

COLD PRESSOR TEST

PURPOSE

To determine vascular hyperactivity.

EQUIPMENT

Sphygmomanometer and stethoscope
Basin ice water
Pen
Standard Form 512, Plotting Chart

PROCEDURE

1. Have patient remain in supine position for 20 - 60 minutes before and throughout test.
2. Place blood pressure cuff on arm.
3. Several readings of the blood pressure are taken during this time, until a basal level has been established.
4. Immerse hand and wrist of opposite arm in ice water 4° C. for 60 seconds and check the blood pressure at 30 and 60 second intervals during immersion.
5. Take blood pressure every two minutes thereafter until basal level is again reached.
6. Graph blood pressure reading before, during and after immersion, on SF-512.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ABDOMINAL PARACENTESIS

PURPOSE

To aspirate fluid from the abdominal cavity.

EQUIPMENT

Sterile paracentesis tray
Sterile gloves
Sterile specimen container
Local anesthesia solution
Alcohol sponges
Skin disinfectant solution
Protective sheet or pads
Large basin for abdominal fluid
Dry sterile dressing
Adhesive tape
Abdominal or scultetus binder
Standard Form 557, Miscellaneous
Standard Form 522, Authorization Permit

PROCEDURE

1. Check chart for signed permit (SF 522).
2. Wash hands.
3. Assemble equipment. Take to bedside.
4. Screen patient and tell him what you are going to do.
5. Have patient empty bladder.
6. Position patient:
   a. Sitting position on side of bed with back and feet supported.
   b. Reclining position - semi-Fowler position in bed.
7. Place protective sheet or pads in position.
8. Place large basin on covered foot stool at bedside.
9. Assist medical officer:
   a. Open sterile tray.
   b. Pour solution for skin preparation.
   c. Cleanse top of local anesthesia solution bottle with alcohol sponge. Hold while medical officer draws solution into syringe.
10. Support the patient physically and mentally during the procedure.
11. Apply dry sterile dressings and binder after treatment is completed. Montgomery straps are used if frequent dressing changes are anticipated. Leave patient comfortable.
12. Measure amount of fluid obtained. Send labeled specimen to laboratory with Standard Form 557.
13. Chart description and amount of fluid and effect of treatment on patient on Nursing Notes and Intake and Output sheet, if applicable.

ABDOMINAL PARACENTESIS (Continued)

POINTS TO EMPHASIZE

1. Shave abdomen if necessary.
2. Watch patient for signs of shock as evidenced by color change, pulse, respiration and profuse perspiration.
3. Provide protection for mattress if patient's incision is to be draining.
4. If procedure is done in the treatment room, always assist patient back to bed.

CARE OF EQUIPMENT

1. Wash equipment with warm soapy water. Rinse and return to CSR.
2. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

LUMBAR PUNCTURE

PURPOSE

To aspirate cerebrospinal fluid.

EQUIPMENT

Sterile Lumbar Puncture Tray
Sterile spinal manometer
Sterile gloves
Skin disinfectant solution
Local anesthesia solution
Protective sheet or pads
Curved basin
Stool or chair
Three Standard Forms 555, Spinal Fluid, and one 554, Microbiology
Standard Form 522, Authorization Permit

PROCEDURE

1. Check patient's chart for signed permit (SF 522).
2. Wash hands.
3. Assemble equipment. Take to bedside.
4. Screen patient and tell him what you are going to do.
5. Place protective sheet or pads in position.
6. Assist medical officer:
   a. Open sterile tray.
   b. Pour solution for skin preparation.
   c. Pour local anesthesia solution into a sterile medicine glass or hold bottle for medical officer to aspirate desired amount.
7. Position patient:
   a. Place patient on his side with back near the edge of the bed.
   b. Flex the body by bringing the knees as close to the chin as possible.
8. Standing on opposite side of bed from medical officer, help patient to maintain correct position by placing one hand on patient's head and second hand under patient's knees.
9. Reassure and support patient mentally during procedure.
10. Apply dressing to site of injection after treatment is completed.
11. Make patient comfortable.
12. Label specimens and send immediately to the laboratory with proper forms.
13. Chart description and approximate amount of fluid, number of specimens sent to the laboratory and effect of treatment on patient on Nursing Notes (SF 510).

LUMBAR PUNCTURE (Continued)

POINTS TO EMPHASIZE

1. Send the specimen to the laboratory immediately and deliver directly to laboratory personnel, since examination should be done within 30 minutes after specimen is obtained.
2. Instruct the patient to remain flat in bed, as ordered after treatment.
3. Three SF 555 are required for routine examination.
   Label: one for chemistry
   one for serology
   one for cell count

ADDITIONAL INFORMATION FOR THIS ACTIVITY

THORACENTESIS

PURPOSE

To aspirate fluid from the chest.

EQUIPMENT

Sterile Thoracentesis Tray
Sterile gloves
Sterile graduated container
Local anesthesia solution
Dry sterile dressings
Alcohol sponges
Skin disinfectant solution
Pillow with plastic pillowcase
Protective sheet or pads
Adhesive tape
Standard Form 557, Miscellaneous, and 554, Microbiology
Standard Form 522, Authorization Permit

PROCEDURE

1. Check chart for signed permit (SF 522).
2. Wash hands.
3. Assemble equipment. Take to bedside.
4. Screen patient and tell him what you are going to do.
5. Place protective sheet or pads in position.
6. Assist medical officer:
   a. Open sterile tray.
   b. Pour solution for skin preparation.
   c. Cleanse top of local anesthesia bottle with alcohol sponge. Hold while medical officer draws solution into syringe.
7. Position patient:
   a. Sitting position - on side of bed with feet resting on chair. Place overbed table with pillow on it in front of patient. Instruct him to rest his head and fold arms on pillow.
   b. Reclining position - on unaffected side close to edge of bed.
8. Reassure and support the patient physically and mentally during procedure.
9. Apply dry sterile dressings over wound after treatment is completed. Leave patient comfortable.
10. Measure amount of fluid obtained. Label specimen and send to laboratory with SF 557.
11. Chart description and amount of fluid and effect on patient on Nursing Notes (SF 510) and Intake and Output chart, if applicable.

THORACENTESIS (Continued)

POINTS TO EMPHASIZE

1. Watch patient for signs of shock as evidenced by changes in color, pulse, respiration and profuse perspiration.
2. If the procedure is done in the treatment room, always assist patient back to bed.

CARE OF EQUIPMENT

1. Wash equipment with warm soapy water. Rinse and return to CSR.
2. Discard disposable items.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

VI

ISOLATION TECHNIQUE

Isolation Technique manuals are available in most naval medical activities and should be used as reference.

Isolation Techniques for use in Hospitals, U.S. Department of Health, Education, and Welfare, Public Health Service, PHS Publication No. 2054, is a reliable reference. It is available from U.S. Government Printing Office, Washington, D.C., 20402, price $1.00.

At activities where local manuals are not available, the Nursing Procedures Manual, NAVMED P-5066, may be used as a reference.

ISOLATION TECHNIQUES

PURPOSE

To prevent transmission of infection from the patient to other persons.
To prevent reinfection of the patient.

PREPARATION OF THE UNIT WITH HANDWASHING FACILITIES
(Sink and running water)

Outside unit:

1. Place "ISOLATION" sign with listed necessary precautions at entrance.
2. Stock locker with disposable or clean gowns, disposable or clean masks and disposable gloves, if applicable.

Inside the Patient's Room:

1. Ascertain that the following is in the room:
   - *a. Hand washing unit:
     - (1) Paper towels in towel dispenser over sink.
     - (2) Soap in soap dispenser which is foot operated.
     - (3) Step-on can lined with water proof bag for used paper towels.
     - (4) Linen hamper.
   - b. At the bedside:
     - (1) Overbed table, chair, bedside locker, overhead bed lamp.
     - (2) Water pitcher and glass.
     - (3) Drinking tube if necessary.
     - (4) Paper bag.
     - (5) Towel and washcloth.
     - (6) Facial tissues.
     - (7) Call bell or signal cord.
     - (8) Clock.
     - (9) Thermometer in disinfectant solution.

*If anteroom is provided between corridor and patient's room, the handwashing unit should be located here.

   - c. In the bedside locker:
     - (1) Toilet articles.
     - (2) Bath Basin.
     - (3) Curved Basin.
     - (4) Bedpan, urinal, paper covers.
     - (5) Toilet tissue.
     - (6) Necessary linen.

ISOLATION TECHNIQUES (Continued)

IMPROVISED ISOLATION TECHNIQUE

Preparation of unit when running water and handwashing facilities are not available:

1. Outside the patient's unit:
   a. Place Isolation sign with listed necessary precautions at entrance.
   b. Stock locker with clean or disposable gowns, clean or disposable masks, and disposable gloves if applicable.
2. Inside the patient's unit:
   *a. Handcleansing unit
      (1) Container of prepackaged disinfectant towelettes on small table at room entrance.
      (2) Paper towels
      (3) Step-on can or waste paper basket with waxed paper bag inside for used towels.
      (4) Linen hamper.
   b. At the Bedside:
      (1) Overbed table, chair, bedside locker, overhead bed lamp.
      (2) Water pitcher and glass.
      (3) Drinking tube if necessary.
      (4) Paper bag.
      (5) Towel and washcloth.
      (6) Facial tissues.
      (7) Call bell or signal cord.
      (8) Clock.
      (9) Thermometer in disinfectant solution.

*The principle of handwashing is primarily that of mechanical removal of dirt, microorganism, etc., by sudsing, friction, and flushing with running water. It is important; therefore, that hands be washed at the nearest sink immediately after leaving the isolation unit described above.

   c. In the bedside locker:
      (1) Toilet articles.
      (2) Bath Basin.
      (3) Curved basin.
      (4) Bedpan, urinal, paper covers.
      (5) Toilet tissue.
      (6) Necessary linen.

ISOLATION TECHNIQUES (Continued)

POINTS TO EMPHASIZE

1. Units selected for isolated patients should have a sink with running water and toilet facilities when possible.
2. All personnel must be aware of the extent of isolation zones.
3. Patients capable of being instructed should be made aware of the isolation areas and the need for isolation.
4. Handwashing unit, whether located within the patient's room or in the anteroom, should be considered a clean area. Preferably, the water spigots and soap dispensers should be operated by knee or foot controls.
5. All personnel should wash hands again under running water after leaving an isolation unit.
6. Ambulatory patients should be instructed not to enter handwashing and isolation areas.
7. Visitors should be kept to a minimum and assisted in gowning and ungowning when entering and leaving the unit. Children should not be allowed to visit patients in isolation.
8. If unit does not contain toilet facilities, patient must use bedpans and urinals and have bed baths since they must be restricted to the isolation unit.
9. Good personal hygiene practices should be observed by all personnel to protect themselves against infection.
10. Disposable urinals and bedpans should be used, if available. Autoclaving is the most reliable decontamination system if nondisposable ones are used.
11. Masks should be discarded in an appropriate receptacle before the user leaves the contaminated area. They must never be lowered around the neck and then reused.
12. When caring for several patients who have the same disease, and who are hospitalized in the same nursing unit or ward, one gown may be worn when caring for this group of patients.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

HANDWASHING TECHNIQUES

PURPOSE

To prevent the spread of contamination from the patient's unit to surrounding areas.

EQUIPMENT

Sink with running water
Soap/detergent in dispenser
Paper towels in container
Step-on can or waste basket lined with water proof bag for towels

PROCEDURE

1. Turn on faucet and leave water running during washing procedure.
2. Wet hands and apply a heavy lather.
3. Lather and wash faucet, if foot or knee controls are not available.
4. Use friction, one hand upon the other.
5. Rinse.
6. Repeat steps 2, 4, and 5.
7. Turn off faucet.
8. Dry hands with paper towel. Discard in waste container.
9. Open gown by loosening tie at neck first.
10. Remove gown and place in hamper.
11. Take clean paper towel, turn on faucet and wash hands and arms and dry with paper towel.
12. If anteroom is available, cleanse hands with disinfectant towelette, remove gown in patient's room and place in hamper. Then carry out hand washing procedure in anteroom area.
    a. If gown is to be reused, cleanse hands with disinfectant towelette, remove gown and hang in patient's room and then go to anteroom and carry out handwashing technique, steps 1 through 7.

POINTS TO EMPHASIZE

1. Hands must be washed before and after patient contact even when gloves are used.
2. Any cuts or abrasions noted on hands should be reported to the doctor or nurse before entering isolation.
3. When sinks are not available in the isolated patient's unit, hands must be disinfected with towelettes in the unit and then washed immediately under running water after leaving the unit.

HANDWASHING TECHNIQUES (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

MASK TECHNIQUE

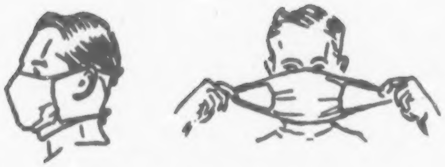
PURPOSE

To prevent the spread of respiratory infection from the patient to personnel and visitors.

EQUIPMENT

Covered container of masks or box of disposable masks on table outside the patient's unit.
Paper bag for used masks in patient's room on side of linen hamper.

PROCEDURE



A. Putting on mask:
   1. Wash or disinfect hands.
   2. Take mask from container.
   3. Open mask by pulling strings.
   4. Place over nose and mouth, tie at back of head and neck.
   5. Adjust mask __before__ going into isolated area.

B. __Taking off mask:__

   1. Wash or disinfect hands.
   2. Untie mask and drop in bag, taking care to touch only strings.
   3. Wash hands.

MASK TECHNIQUE (Continued)

POINTS TO EMPHASIZE

1. Masks become ineffective when moist and should be discarded.
2. Masks must never be lowered around the neck and then be reused.
3. Masks should cover the nose and mouth.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

GOWN TECHNIQUE

PURPOSE

To prevent the spread of contamination from the patient's unit to surrounding areas.

EQUIPMENT

Gown supply in cabinet of bedside locker outside isolation area
Handwashing facilities

PROCEDURE

Putting on gown:
1. Wash hands.
2. Take gown from cabinet.
3. Put on gown and tie at neckband. Overlap back to completely cover uniform. Tie belt at waist.

Taking off gown:
1. Untie belt.
2. Wash or disinfect hands.
3. Untie neckband.
4. Slip out of gown rolling clean side over hands and forearms as it falls forward.
5. Drop in laundry hamper.
6. Wash hands.

IMPROVISED METHOD WHEN GOWNS ARE REUSED

EQUIPMENT

I.V. Standard, clothes tree or wall hooks are located within the patient's room
Gown which has been used
Handwashing or disinfecting facilities

PROCEDURE

Putting on gown:
1. Gown will be hung so that the contaminated side is out. Grasp gown by neckband and slip hands and arms into sleeves, taking care not to touch the outside of the gown.
2. Place fingers inside neckband, draw gown into place. Tie neckband.
3. Bring back edges of gown together so that inside of one side is in contact with inside of gown on other side. Lap over.
4. Grasp belt. Bring to back and tie.

6

GOWN TECHNIQUE (Continued)

PROCEDURE (Continued)

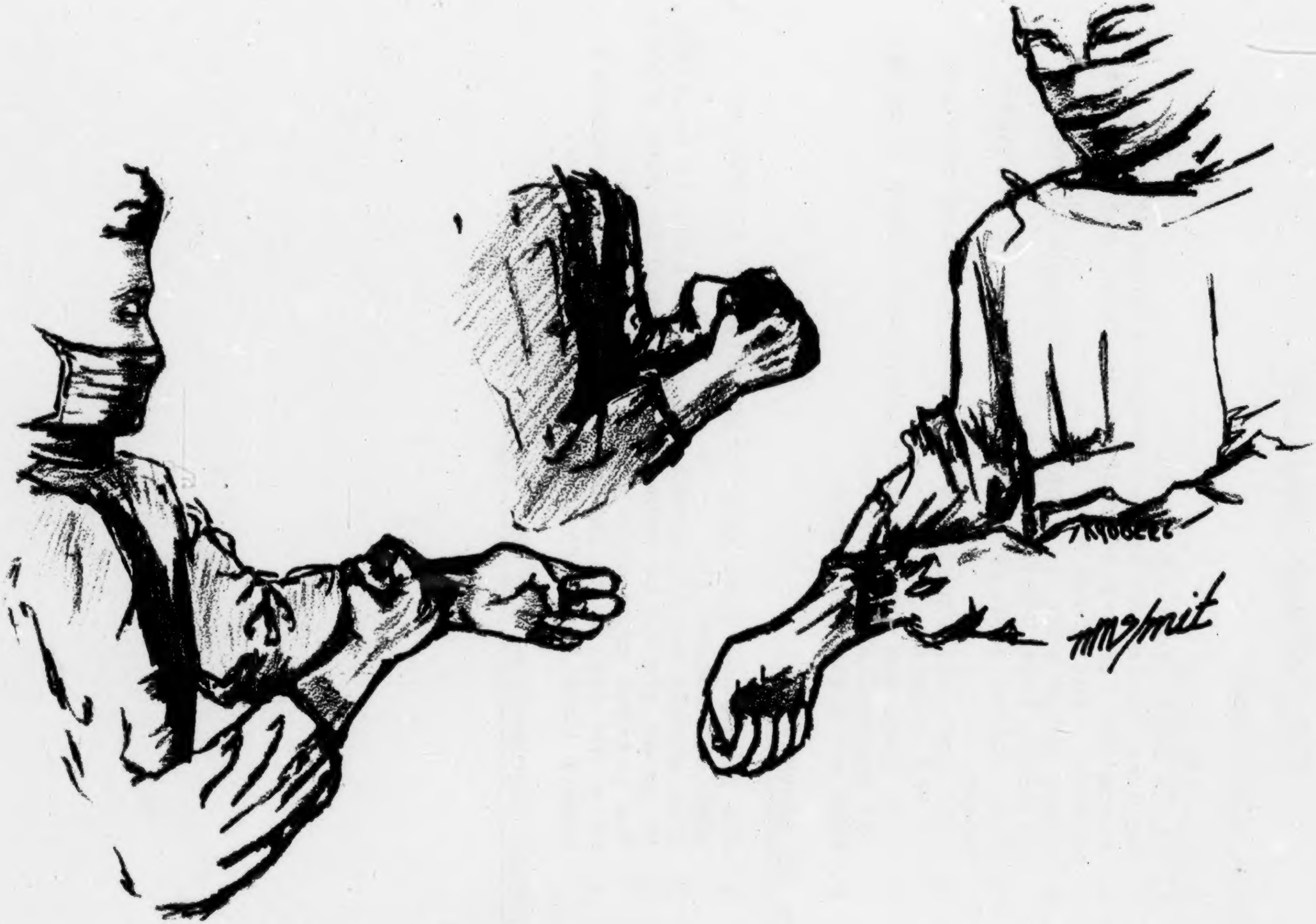
Taking off gown:

1. Untie belt. Loop in front.
2. Wash or disinfect hands. Untie strings at neck.
3. Place two fingers of right hand under cuff of left sleeve. Pull down over hand.
4. Grasp outer part of right cuff through sleeve covering left hand.
5. Slip out of gown by working hands up to shoulder seams.
6. Lift gown off shoulders touching only the neckband on the outside.
7. Fold gown and hang on hook with back seams together and contaminated side out.
8. Wash or disinfect hands.

POINTS TO EMPHASIZE

1. All personnel must know precisely how to put on gown and remove it.
2. Gown should be discarded after each use, if possible.
3. If gowns are to be reused they should be hung within the patient care unit - not in the corridor.
4. If gowns are to be reused they should be discarded always when they are wet and every 3-4 hours.

ADDITIONAL INFORMATION FOR THIS ACTIVITY



Gown Technique

CARE OF LINEN

(Double-bag Technique)

PURPOSE

To prevent the spread of contamination from the patient's unit to the surrounding area.

EQUIPMENT

Linen bags
Linen hamper

PROCEDURE

1. Place hamper bag over back of chair in unit.
2. Place linen in bag as it is removed from bed.
3. If only one patient is isolated, the linen hamper for contaminated gowns may be used for bed linen.
4. Close bag tightly and then place in a second clean bag, preferably a different color, which is held by a second person or supported by a hamper outside the patient's room.
5. Close bag tightly and label "CONTAMINATED".

POINTS TO EMPHASIZE

1. Never shake out linen when removing from bed and transferring to linen hampers.
2. If hot water-soluble bag is used, it should be the inner bag.
3. Use disposable linens when available.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

SERVING FOOD WITH DISPOSABLE DISHES

PURPOSE

To provide nourishment to the patient and prevent spread of contamination.

EQUIPMENT

Disposable dishes and utensils
Disposable water proof bags

PROCEDURE

1. Notify kitchen to serve patient's food on disposable dishes.
2. Wash hands.
3. Obtain tray from food cart and transfer food on disposable dishes to tray in patient's room.
4. Prepare in usual manner.

AFTER MEAL

1. Enter room in usual manner bringing in disposable tray bag.
2. Pour all liquid waste food into commode in room and flush. (If no commode, empty into hopper in in utility room taking care not to contaminate utility room.)
3. Place all refuse and paper containers in the disposable bag and wrap securely. Place in clean bag that has been placed just outside the unit.
4. Wipe tray clean and replace in designated place within patient's unit.
5. Make patient comfortable and arrange unit.
6. Remove gown, gloves, and mask, if used, washing in the usual manner.
7. Carry bag containing refuse to utility room, or galley and place in garbage can for usual garbage disposal.

POINTS TO EMPHASIZE

1. Be sure all refuse is removed from the room after each meal.
2. Wash tray after each meal and retain in patient's unit; same tray is used for same patient at each meal.

SERVING FOOD WITH DISPOSABLE DISHES (Continued)

ADDITIONAL INFORMATION FOR THIS ACTIVITY

MEDICATIONS FOR THE ISOLATED PATIENT

PURPOSE

To provide medications and prevent spread of infection.

EQUIPMENT

Disposable medicine cups
Disposable syringe and needles
Medication tray

PROCEDURE

1. Assemble medications as described on page 116.
2. Put on isolation gown and gloves (if needed).
3. Bring medications into room. (If a tray is used to carry medications it must be left outside the room.)
4. Administer medication in the usual manner. Discard cup and other disposable equipment in waste basket.
5. Remove isolation garments in the usual manner, page 419.
6. Wash hands. (Page 414)
7. Record medication.

POINTS TO EMPHASIZE

1. Oral medications are prepared in disposable cups.
2. For medications administered by injection, disposable syringes and needles are always used.

CARE OF EQUIPMENT

1. Discard all disposable equipment.
2. Break off tips of needles and syringes before discarding.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

CARE OF BODY DISCHARGES AND EXCRETA

PURPOSE

To discard body secretion and prevent contamination.

NOSE AND THROAT DISCHARGES

EQUIPMENT

Waxed paper bag
Sputum cups
Paper wipes

PROCEDURE

1. Supply each patient having nose and throat discharges with paper bag and paper wipes. If sputum is copious supply sputum cup.
2. Instruct patient to:
   a. Cover his mouth and nose with wipes held in cup like fashion whenever he coughs, sneezes or talks to people.
   b. Place used wipes directly into paper bag pinned to bed.
   c. Ask for new sputum cup when one is half full.
3. Distribute clean bags and sputum cups every 8 hours or oftener, if necessary.
4. Collect bags. Close tightly. Place in trash can for incineration.

EXCRETA

PROCEDURE

1. Each patient should have his own bedpan and urinal.
2. Use paper covers for bedpans and urinals.
3. Empty bedpans and urinals directly into bedpan flusher.
4. Press steam valve for two minutes. Use paper towel on handle of steam valve.
5. Remove bedpan/urinal and return to patient's unit.
6. Wash hands.
7. When patient is ordered out of isolation the bedpan and urinal should be sterilized by autoclaving.
8. Disposable bedpans and urinals should be used when available.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

TERMINAL DISINFECTION

PURPOSE

To eliminate and destroy pathogenic organisms in the patient's unit when a patient is discharged.

PROCEDURE

1. Give patient complete bath and shampoo; give clean clothes and assign to non-isolated bed.
2. Put on gown (gloves and mask if indicated) when cleaning unit.
3. Strip unit/cubicle or room.
   a. Place all washable linen directly into "Contaminated" laundry bag/hamper.
   b. Place blanket and pillow in separate laundry bag. Mark "Special contaminated-blanket, pillow."
   c. Place all disposable materials in plastic bag outside the room in waste container.
   d. Send all utensils, instruments and thermometers to CSR for terminal sterilization.
      (1) Place in plastic bag and mark appropriately.
4. Wash bed, bedside locker, chair, overbed table and entire cubicle or room with a germicical detergent solution, including walls up to six feet. Rinse. Allow to air dry.
   a. Sponge plastic mattress cover with germicidal detergent. If mattress was not protected by plastic cover and is grossly soiled with infectious discharges, burning should be considered.
5. If possible, air cubicle or room with windows open and door closed for 2-4 hours before preparing for another patient.

ADDITIONAL INFORMATION FOR THIS ACTIVITY

ISOLATION PROCEDURES FOR SPECIFIC COMMUNICABLE DISEASES

Type of Isolation	Diseases	Precautions
I. Strict Isolation	1. Anthrax, inhalation 2. Burns, extensive and infected 3. Diptheria 4. Eczema vaccinatum 5. Meliodosis 6. Neonatal vesicular disease 7. Plague 8. Rabies 9. Rubella and congenital Rubella syndrome 10. Smallpox 11. Staphylococcal enterocolitis 12. Staphylococcal pneumonia 13. Streptocaccal pneumonis 14. Vaccinia, generalized and progressive	1. Private Room - necessary 2. Gowns - must be worn by all persons entering room 3. Masks - must be worn by all persons entering room 4. Hands - must be washed on entering and leaving room 5. Gloves - must be worn by all persons entering room 6. Articles - must be discarded, or wrapped before being sent to CSR for disinfection or sterilization
II. Respiratory Isolation	1. Chickenpox 2. Herpes yoster 3. Measles (rubeola) 4. Meningococcal meningitis	1. Private room - necessary 2. Gowns - not necessary 3. Masks - must be worn by all persons entering room 4. Hands - must be washed on entering and leaving room 5. Gloves - not necessary

ISOLATION PROCEDURES FOR SPECIFIC COMMUNICABLE DISEASES
(Continued)

Type of Isolation	Diseases	Precautions
II. Respiratory Isolation (Continued)	5. Mumps 6. Meningocaccemia 7. Pertussis 8. Rubella 9. Tuberculosis, pulmonary-sputum-positive or suspect 10. Venezuelan equine encephalomyelitis	6. Articles - those contaminated with secretions must be disinfected
III. Protective Isolation	1. Agranulocytosis	1. Private room necessary with sterile sheets 2. Gowns - sterile - worn by all persons entering the room 3. Masks - worn by all persons entering the room 4. Hands - must be washed on entering and leaving the room 5. Gloves - must be worn by all persons having direct contact with patient 6. Articles - No special precautions 7. Visitors - limited
IV. Enteric Isolation	1. Cholera 2. Enteropathogenic E. Coli gastroenteritis 3. Hepatitis, viral (infectious or serum) 4. Salmonellosis (including typhoid fever)	1. Private room - necessary for children only 2. Gowns - must be worn by all persons having direct contact with patient 3. Masks - not necessary 4. Hands - must be washed on entering room 5. Gloves - must be worn by all persons having direct contact with patient or with artcles contaminated with fecal material

ISOLATION PROCEDURES FOR SPECIFIC COMMUNICABLE DISEASES
(Continued)

Type of Isolation	Diseases	Precautions
IV. Enteric Isolation (Continued)	5. Shigellosis	6. Articles - those contaminated with urine or feces must be disinfected or discarded
V. Wound and Skin Precautions	1. Gas gangrene 2. Impetigo 3. Staphloccal wound infections	1. Private room - desirable 2. Gowns - worn by all persons having direct contact with patient 3. Masks - Not necessary except during dressing changes 4. Hands - must be washed on entering and leaving room 5. Gloves - must be worn by all persons having direct contact with infected area 6. Articles - no special precautions except for those contaminated by drainage from infected area

VII

TABLE OF ABBREVIATIONS

TABLE OF ABBREVIATIONS

@	at
A.	admitted to hospital
āā	of each
abd	abdomen
a.c	before meals
ad lib	as desired
AFB	acid fast bacillus
a.m.	morning
amp	ampule
amt	amount
AOW	admitted from other ward
Ba. E	barium enema
b.i.d	twice a day
BMR	basal metabolic rate
BP	blood pressure
BSP	bromsulphalein
BUN	blood urea nitrogen
C	centigrade
c̄	with
Ca	calcium
cap	capacity beds, capsule
cath	catheterize
CBC	complete blood count
cc	cubic centimeter
Cl	chloride
CLR	census last report
cm	centimeter
comp	compound
CO_2 vol.%	carbon dioxide volume
CSR	central supply room or central dressing room
C and S	culture and sensitivity
D	discharged from hospital
DD	discharged by death
DC	discontinued
diff	differential count
DOA	dead on arrival
DOS	day of surgery
dr	dram
Dr	doctor
D/NS or D/S	dextrose in normal saline
D/W	dextrose in water
ECG or EKG	electrocardiogram
EEG	electroencephalogram
EENT	eye, ear, nose and throat

TABLE OF ABBREVIATIONS (Continued)

elix	elixir
exam	examination
ext	extract
F	fahrenheit
FBS	fasting blood sugar
Fe	iron
Fr	French, denotes size of catheter or tube
ft	feet, foot
GB	gallbladder
GI	gastrointestinal
Gm	gram
gr	grain
GTT	glucose tolerance test
gtt	drop/drops
GU	genitourinary
GYN	gynecology
"H." or S.C	hypodermic/subcutaneous
h. or hr	hour
hgb	hemoglobin
Hg	mercury
HP	head privileges
HS or hs	at bedtime
ht	height
HCl	hydrochloric acid
IM	intramuscular
I and O	intake and output
in	inch
I.V	intravenous
IVP	intravenous pyelogram
K	potassium
KCl	potassium chloride
kg	kilogram
L	leave or liberty
Lab	laboratory
LLL	left lower lobe
LLQ	left lower quadrant
LP	lumbar puncture
LUL	left upper lobe
LUQ	left upper quadrant
m	minim
mcg	microgram
Med	medical, medicine
mEq	milliequivalent
mg. or mgm	milligram, one thousandth of a gram

TABLE OF ABBREVIATIONS (Continued)

ml................	milliliter
min...............	minute, minim
mm................	millimeter
Na................	sodium
NaCl..............	sodium chloride
no................	number
NP................	neuropsychiatric
NPN...............	non protein nitrogen
NPO...............	nothing by mouth
NSS or NS.........	normal saline solution
OB................	obstetrical or maternity
O_2................	oxygen
oint..............	ointment
OOD...............	Officer of the Day
OR................	operating room
OPD...............	outpatient department
OT................	occupational therapy
oz................	ounce
P.................	phosphorus
P.................	pulse
PAL...............	prisoner at large
P.B.I.............	protein bound iodine
Ped...............	pediatrics or children
p.c...............	after meals
Pharm.............	pharmacy
p.m...............	afternoon, evening
p.o...............	by mouth
POD...............	postoperative day
Postop............	after surgery
P.P.D.............	purified protein derivative
p.r.n.............	when necessary
Preop.............	before surgery
PSP...............	phenolsulfonphthalein
PT................	physical therapy
pt................	patient/pint
q.................	every
q.d...............	every day
q.h...............	every hour
q. 2 h............	every 2 hours
q. 3 h............	every 3 hours
q. 4 h............	every 4 hours
q.i.d.............	four times a day
q.n...............	every night
q.s...............	a sufficient quantity

TABLE OF ABBREVIATIONS (Continued)

qt	quart
R	respiration, rectal, right
R and M	routine and microscopic
RBC	red blood count
RLL	right lower lobe
RLQ	right lower quadrant
RML	right middle lobe
RUL	right upper lobe
RUQ	right upper quadrant
s̄	without
SAH/SO	subsisting at home/out
S.C. or subcut	subcutaneous/hypodermic
Sed. rate	sedimentation rate
SL	serious list
sol	solution
SOQ	sick officers' quarters
Sp	spirit
spec	specimen
sp.gr	specific gravity
s̄s̄	half
S.S.E.	soap solution enema
stat	immediately
Surg	surgical
T	temperature
tab	tablet
TB	tuberculosis
T. or tbsp	tablespoon
t.i.d	three times a day
tinct. or tr	tincture
TOW	transfer to other ward
T.P.R	temperature, pulse, respiration
t. or tsp	teaspoon
U	unit
U.A	Unauthorized Absence
Vac	vacant beds
VSL	Very Serious List
WBC	white blood count
Wd	ward
wt	weight

TABLE OF ABBREVIATIONS

WARD ADMINISTRATION

(Nursing Notes, Doctor's Orders, and Ward Records)

A.	admitted to hospital
abd	abdomen
a.m.	morning
amt	amount
AOW	admitted from other ward
BP	blood pressure
C	centigrade
cap	capacity
CLR	census last report
CSR	central supply room
D	discharged from hospital
DD	discharged by death
DOA	dead on arrival
DOS	day of surgery
Dr	doctor
E.E.N.T.	eye, ear, nose, and throat
exam	examination
F	fahrenheit
Fr	French, denotes size of catheter or tube
ft	feet, foot
GU	genitourinary
GYN	gynecology
HP	head privileges
ht	height
I&O	intake and output
in	inch
kg	kilogram
L	leave or liberty
LLL	left lower lobe
LLQ	left lower quadrant
LP	lumbar puncture
LUL	left upper lobe
LUQ	left upper quadrant
Med	medical, medicine
no	number
NP	neuropsychiatric
NPO	nothing by mouth
OB	obstetrics
occ	occupied
OOD	officer of the day
OR	operating room
OPD	outpatient department
OT	occupational therapy

TABLE OF ABBREVIATIONS

WARD ADMINISTRATION (Continued)

P	Pulse
PAL	prisoner at large
Ped	pediatrics or children
Pharm	pharmacy
p.m	afternoon, evening
POD	postoperative day
Postop	after surgery
Preop	before surgery
PT	physical therapy
pt	patient
R	respiration, rectal, right
RLL	right lower lobe
RLQ	right lower quadrant
RML	right middle lobe
RUL	right upper lobe
RUQ	right upper quadrant
SAH/SO	subsisting at home/out
SL	serious list
SOQ	sick officers' quarters
Surg	surgical
T	temperature
TB	tuberculosis
TOW	transfer to other ward
T.P.R	temperature, pulse, and respiration
UA	unauthorized absence
Vac	vacant beds
VSL	very serious list
Wd	ward
wt	weight

TABLE OF ABBREVIATIONS

MEDICATIONS/TREATMENTS

@	at
$\overline{aa}$	of each
a.c	before meals
ad lib	as desired
amp	ampule
b.i.d	twice a day
$\bar{c}$	with
Ca	calcium
cap	capsule
cath	catheterize
cc	cubic centimeter
Cl	chloride
cm	centimeter
comp	compound
DC	discontinued
dr	dram
D/NS or D/S	dextrose in normal saline
D/W	dextrose in water
elix	elixir
ext	extract
Fe	iron
Gm	gram
gr	grain
gt./gtt	drop/drops
"H" or S.C	hypodermic/subcutaneous
h. or hr	hour
Hg	mercury
HS or hs	at bedtime
HCl	hydrocloric acid
IM	intramuscular
I.V	intravenous
K	potassium
KCl	potassium chloride
m	minim
mcg	microgram
mEq	milliequivalent
mg. or mgm	milligram
ml	milliliter
min	minute
mm	millimeter
Na	sodium
NaCl	sodium chloride
NSS or NS	normal saline solution
O_2	oxygen
oint	ointment
oz	ounce
P	phosphorus
p.c	after meals

TABLE OF ABBREVIATIONS

MEDICATIONS/TREATMENTS (Continued)

p.o.	by mouth
p.r.n.	when necessary
pt	pint
q	every
q.d	every day
q.h	every hour
q.2h	every 2 hours
q.3h	every 3 hours
q.4h	every 4 hours
q.i.d	four times a day
q.n	every night
q.s	a sufficient quantity
qt	quart
s̄	without
S.C. or subcut	subcutaneous
Sol	solution
sp	spirit
s̄s̄	half
S.S.E	soap solution enema
Stat	immediately
tab	tablet
T. or tbsp	tablespoon
t.i.d	three times a day
tinct. or tr	tincture
t. or tsp	teaspoon
U	unit

TABLE OF ABBREVIATIONS

LABORATORY/X-RAY

AFB	acid fast bacillus
Ba.E	barium enema
BMR	basal metabolic rate
BSP	bromsulphalein
BUN	blood urea nitrogen
CBC	complete blood count
CO_2vol.%	carbon dioxide volume
C and S	culture and sensitivity
diff	differential count
ECG or EKG	electrocardiogram
EEG	electroencephalogram
FBS	fasting blood sugar
GB	gallbladder
GI	gastrointestinal
GTT	glucose tolerance test
hbg	hemaglobin
IVP	intravenous pyelogram
Lab	laboratory
NPN	non protein nitrogen
P.B.I	protein bound iodine
P.P.D	purified protein derivative
PSP	phenolsulfonphthalein
R and M	routine and microscopic
RBC	red blood count
Sed.rate	sedimentation rate
spec	specimen
sp.gr	specific gravity

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